CUESTA COLLEGE

Cuesta College Psychiatric Technician Program

REV (3/2018)

10333 El Camino Real, Atascadero, CA 93422 Phone: (805) 468-3175

IMMUNITY FORM

IMPORTANT! THIS FORM IS TO BE FILLED OUT IN ITS ENTIRETY BY YOUR HEALTHCARE PROVIDER. HOWEVER, THIS FORM ALONE DOES NOT SERVE AS PROOF OF IMMUNITY. YOU MUST ATTACH RECORDS OF ALL VACCINATIONS, LABS, ETC. TO THIS FORM.

1. Either you or your healthcare provider, indicate completion of EACH immunity requirement listed below.
2. If you need titers to verify immunity, you must request lab titer orders from a healthcare provider. PLEASE NOTE THE TITERS ARE "IgG", and you should indicate this to your provider when requesting your titer orders, or you may have to repeat these tests and pay for them again.

PATIENT'S NAME_____**DATE OF BIRTH:**_____

IMMUNITY REQUIREMENT		Date of 1st Vaccine	Date of 2nd Vaccine	Date of 3rd Vaccine	Result of Titer (IgG) and Date
MMR Vaccine *x 2 OR individual vaccines or titer results below*				N/A	N/A
Not needed if MMR 1 & MMR 2 have been completed	**Rubeola** (Measles) vaccine *OR positive titer result*			N/A	
	Mumps vaccine *OR positive titer result*			N/A	
	Rubella (German Measles) vaccine *OR positive titer result*			N/A	
Varicella Vaccine (Chickenpox) x 2 *OR positive titer results* *(Documented history of Varicella exposure is not accepted)*				N/A	
Hepatitis B Vaccine x 3 *OR positive titer result* *If all 3 vaccines have not been completed, the 1st vaccine MUST be received by the Program or Course due date. The 2nd vaccine to be completed one month after receiving the 1st vaccine; and the 3rd vaccine to be completed, at least, 5 months after receiving the 2nd vaccine.*					
Tdap Vaccine *x 1 (Tdap vaccine must be 2005 or later, with a Td booster every 10 years)*			N/A	N/A	N/A
Flu Vaccine if applicable (October – April)			N/A	N/A	N/A

HEALTHCARE EXAMINER VERIFICATION

- ❑ I confirm that this student has met ALL the immunization and/or screening requirements indicated above.
- ❑ Hep B, MMR and/or Varicella series in-progress. (Student may begin the program/course with the 1st vaccine of the series completed as long as they submit a plan to the Program Office before the deadline).

Examiner's Stamp & Address

Health Examiner Signature:_____ **Date:** _____

Print Name: _____ **Phone**: _____