As a part of the application process students are required to submit a record of the immunizations listed below.

**The student is responsible for any cost associated with immunizations.**

**IMMUNIZATIONS REQUIRED**

* Annual PPD (purified protein derivative)
  + The PPD skin test is a method used to diagnose silent (latent) [tuberculosis](http://www.nlm.nih.gov/medlineplus/ency/article/000077.htm) (TB) infection. PPD stands for purified protein derivative.
  + If the PPD is considered positive a Chest radiograph is required, every three years.
* Annual Flu Shot
  + Established by the date of vaccination
* Hepatitis B immunization
  + established by three reported dates of immunization or by documented testing of quantitative antibody titer
* Tetanus diphtheria
  + every 10 years
* Rubella, Rubeola & Mumps immunity
  + established by two reported dates of vaccination or documented quantitative antibody titer
* Varicella immunity
  + established by documented history or quantitative antibody titer or date of vaccination.

**SUBMISSION OF IMMUNIZATION RECORD**

**Athletic training students are required to submit proof of the following immunizations during the application process and annually (for yearly immunizations) prior to being allowed to complete any practicum rotations.**

* The immunization must be valid for the entire academic year in order to be considered cleared for practicum rotations.

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **UIN#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **COHORT YEAR:** \_\_\_\_\_\_\_\_

**Hepatitis B:** 1st: \_\_\_\_\_\_\_\_\_\_\_ 2nd: \_\_\_\_\_\_\_\_\_\_ 3rd: \_\_\_\_\_\_\_\_\_\_ **OR** Titer: \_\_\_\_\_\_\_\_\_\_\_\_

DATE DATE DATE DATE

**Tetanus diphtheria:** \_\_\_\_\_\_\_\_\_\_\_\_

DATE

**Rubella, Rubeola & Mumps:** 1st: \_\_\_\_\_\_\_\_\_\_\_ 2nd: \_\_\_\_\_\_\_\_\_\_ **OR** Titer: \_\_\_\_\_\_\_\_\_\_\_\_

DATE DATE  DATE

**Varicella:** \_\_\_\_\_\_\_\_\_\_\_\_\_ OR Titer: \_\_\_\_\_\_\_\_\_\_\_\_\_ **OR** Vaccination: \_\_\_\_\_\_\_\_\_\_\_\_\_

DATE  DATE DATE

**Annual Tuberculosis Skin Tests (to be completed yearly):**

Application/

Professional Year 1: \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_ If positive – Chest x-ray: \_\_\_\_\_\_\_\_\_\_

DATE  DATE DATE

Professional Year 2: \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_ If positive – Chest x-ray: \_\_\_\_\_\_\_\_\_\_

DATE  DATE DATE

**Annual Flu Shot (to be completed yearly):**

Application/

Professional Year 1: \_\_\_\_\_\_\_\_\_\_ Professional Year 2: \_\_\_\_\_\_\_\_\_\_

DATE   DATE

\*\*\*\* Please attach copies of the original immunization records.\*\*\*\*