PROVIDENCE
Health & Services
Alaska

Immunization Documentation

Name:_____ Date:_____

School (if applicable):_____

Date

_____ MMR (Measles, Mumps, Rubella) Vaccination (1st)
_____ MMR (Measles, Mumps, Rubella) Vaccination (2nd)
OR
_____ Titer Showing Immunity

AND

_____ Chicken Pox (Varicella) Vaccination (1st)
_____ Chicken Pox (Varicella) Vaccination (2nd)
OR
_____ Titer Showing Immunity

AND

_____ Non-reactive TB test (0 mm PPD) within past 12 months (1st)
_____ Non-reactive TB test (0 mm PPD) within past 12 months (2nd)
OR
_____ if positive PPD, medical clearance within past 12 months

_____
Printed Name & Signature of School Nurse or Health Care Provider