Broward General Medical Center
VISITING STUDENT & RESIDENT IMMUNIZATION RECORD

Student's Name_____ **Birth Date**_____

The North Broward Hospital District requires that all medical students and residents requesting a clinical rotation meet all of the immunization requirements listed below. All applicants must submit this completed immunization form in order to be considered for an elective at the North Broward Hospital District. This form must be completed, signed and dated by a health care provider. Applicants should be free from symptoms of infectious disease at the start of their elective. Should you become ill with a communicable disease during enrollment, you are required to notify this office and your course director/attending immediately and remove yourself from patient care activity.

DATE:	**IMMUNIZATION:**
Dose 1_____	**HEPATITIS B:** Applicant must have received three doses of the vaccine or have had a protective titer (Circle one & provide dates)
Dose 2_____	
Dose 3_____	
Date: _____	**MEASLES:** Applicant must have received primary immunization. Proved date of booster, or when titer was drawn, or when student/ resident had disease (Circle one & provide dates)
Date: _____	**MUMPS:** Applicant must have received primary immunization. Provide date of Booster, or when titer was drawn or when student /resident had disease (circle one and provide date).
Date: _____	**RUBELLA:** Applicant must have received primary immunization. Provide date of Booster, or when titer was drawn or when student/resident had disease (circle one and provide date).
Date: _____	**TETANUS-DIPHTHERIA:** Applicant must have received a tetanus-diphtheria booster within the last 10 years (provide date).
Date: _____	**TUBERCULOSIS:** Applicant must have received a PPD test within 3 months of the requested elective date with a negative result; or had a BCG vaccine and a negative chest x-ray (circle one and provide date).
Date: _____	**VARICELLA:** Applicant must have had disease, or has had a protective titer (circle one and provide date)
Date: _____	**POLIO**: Applicant must have completed primary series of polio immunizations. Student/ resident had live (OPV); Inactivated; Enhanced Potency (E-IPV) (circle one and provide date).

Health Care Provider:

Name: _____ **Date:** _____

Signature: _____ **Phone:** _____

Address: _____