Wake Forest University School of Medicine
Student & Teammate Health
Winston Salem, NC 27101

Office: 336-716-0131
StudentHealth@wakehealth.edu

Last Name: ______________________ **First Name:** _______________ **Middle Name:** _____________

Date of Birth: _____/______/______

MEASLES VACCINES OR 2 MMR	OR	MEASLES/RUBEOLA ANTIBODY
Date 1: _______ / _______ / ________ Date 2: _______ / _______ / _______		Date: _______ / _______ / _____ Results: ❏ Positive ❏ Negative
MUMPS VACCINE OR 2 MMR	OR	MUMPS ANTIBODY
Date 1: _______ / _______ / ________ Date 2: _______ / _______ / _______		Date: _______ / _______ / _____ Results: ❏ Positive ❏ Negative
RUBELLA VACCINE OR 1 MMR	OR	RUBELLA ANTIBODY
Date: _______ / _______ / ________		Date: _______ / _______ / _____ Results: ❏ Positive ❏ Negative

HEPATITIS –B : Recommended for those at risk of blood/body fluid exposure.	HEPATITIS B VACCINE AND	HEPATITIS B ANTIBODY
❏ Yes ❏ Declination	Date 1: _______ / _______ / _______ Date 2: _______ / _______ / _______ Date 3: _______ / _______ / _______	Date: _______ / _______ / _______ Results: ❏ Positive ❏ Negative

VARICELLA VACCINATION (2 VACCINATIONS)	OR	VARICELLA ANTIBODY
Date 1: _______ / _______ / ________ Date 2: _______ / _______ / _______		Date: _______ / _______ / ____ Results: ❏ Positive

Tuberculosis (TB) Testing: All students must have either Mantoux tuberculin skin tests (TST) or Interferon Gamma Release Assay (IGRA) no earlier than 1 year prior to matriculation date unless a previous positive test has been documented.

Tuberculin Skin Test: Date administered: ___/___/___ Date read: ___/___/___ Result: ______mm
Tuberculin Skin Test: Date administered: ___/___/___ Date read: ___/___/___ Result: ______mm

OR

IGRA/TB Lab Test Results: Date: _______ / _______ / _______ ❏ Positive ❏ Negative

If Positive documentation of Mantoux or IGRA lab test: Chest X-Ray completed after test is required
If chest x-ray positive: History of INH treatment and WFBMC TB Questionnaire is **required**.

Tetanus booster OR Tdap within past 10 years **Tetanus** _____ **Tdap** ______ Date: _______ / _______ / _______

COVID Vaccine(s)

1. Mfr:_____________ Date: ______ /______ /______
2. Mfr:_____________ Date: ______ /______ /______
3. Mfr:_____________ Date: ______ /______ /______

Seasonal Influenza Vaccine Date: _____ / _____ / _____

To my knowledge, this individual is free from communicable diseases that could pose significant risk to the health and safety of others, and has no physical or mental conditions that would prevent him/her from performing the essential duties required with or without reasonable accommodations.

____ ______________

Signature of Health Care Provider OR Stamp of Health Care Provider Clinic **Date Signed/Stamped**