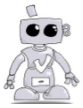

MGH Institute of Health Professions Health History and CPR Certification Form

Part I – To be completed by the student

Name: (Please Print Clearly) _____ Last, First, Middle	**Date of Birth:** ____/____/____ Month Day Year
Address: _____ Street Apt. City State Zip	

Part II – To be completed by your primary care provider, former pediatrician or student health service.

Measles, Mumps and Rubella (MMR) Vaccinations (2 doses required): Dose #1 given at age 12-15 months or later and Dose #2 given at age 4-5 years or later and at least one month after first dose. **OR** **Date of positive antibody titers to:**	**1).** _____ **Measles:** _____ **Mumps:** _____ **Rubella:** _____	**2).** _____ **Immune____Non-immune_____** **Immune____Non-immune_____** **Immune____Non-immune_____**	
Tetanus, Diptheria, Pertussis (TDap) – within last 10 years	**Date:** _____		
Dates of Varicella vaccines (given at least 1 month apart): **OR** **Date of positive antibody titer to Varicella:** **OR** **Primary care verification of history of disease** (month and year of disease is required)	**1).** _____ _____ **Month/Year:** _____	**2).** _____**/ OR** **Immune ____Non-immune____**	
Dates of Hepatitis B vaccinations: **OR** **Date of positive surface antibody titer to Hep B:** (must be completed before first day of classes)	**1).** _____ _____	**2).** _____ **Result: Neg____Pos_____**	**3).** _____
Last TB skin test (PPD/Mantoux): (May never be more than one year old during matriculation) If PPD is positive, chest x-ray is required After submitting a normal chest x-ray at entry, an annual note from your health care provider that you are symptom free or a repeated normal chest x-ray will satisfy the yearly test required.	**Date:** _____ **X-Ray Date:**_____	**Result:** _____**mm** **Result: Neg_____Pos_____**	**QuantiFERON/T-Spot** **Date:**_____ **Result: Neg ____Pos____**
Influenza vaccine: **Influenza vaccine due by 10/1 annually** **Note: Certain agencies may not place students into clinical assignments who decline the flu vaccine**	**Date:** _____	**OR** **Initial here if declined: ____**	
CPR for Health Care Providers Requirement: (**you MUST take one of these courses**) American Heart Association BLS -or- American Red Cross BLS for Health Care Providers	**Expiration Date:** _____	**Student Initials:** _____	Please upload a copy of your CPR certification
Physical Exam: (required annually)	**Date:** _____		

Provider's Signature: _____ *Provider's Name (printed):* _____

Provider's Address: _____

Students: Be sure to sign the release statement below

I have reviewed this Health History and CPR Certification Form for completeness and agree to release the information provided on the MGH Institute of Health Professions Immunization Transcript to authorized members of the Institute staff and authorized staff of cooperating agencies, as may be required.

Print student name: _____ Date of Birth: _____

Student Signature: _____ Date: _____