

Physician Mentoring Program

*IMMUNIZATION HISTORY

*Please fill out this form
 and attach copies of
 immunization records*

Name _____

Must have ALL of the below Vaccinations in order to be accepted in to the program

MMR Vaccine #1. _____ → Date:

MMR Vaccine #2 _____ → Date:

Chicken Pox Vaccine #1 _____ → Date:

Chicken Pox Vaccine #2 _____ → Date:

OR Chicken Pox disease verified in writing by MD, with copy attached

Date of Verification

Tdap (one dose of Adacel or Boostrix given since age 11) _____ → Date:

Copies of all immunization records attached? Yes No

Please do not submit your application without this form completed and copies of your immunization records attached. Your application will not be accepted if incomplete.

*PPD TEST-PARENTAL CONSENT

In compliance with regulatory requirements and hospital policy, mentor students are required to have a PPD Test in order to participate in hospital training activities. The hospital has arranged for the Registered Nurses in the Education Department of Marian Regional Medical Center to administer, read and record the results of this test. By signing this form I, as parent/guardian of this student, am authorizing the Marian Regional Medical Center Education Department RN to administer this test.

_____ has my permission to receive the PPD test for TB from the staff of the Education Department of Marian Regional Medical Center.

DATE _____

PRINT NAME _____ PARENT SIGNATURE _____

STUDENT SIGNATURE: _____ PRINT NAME: _____

ADDRESS: _____

CITY/STATE/ZIP _____ PHONE _____