

Volunteer Services Department **Immunization Record**

Date ___ / ___ / ___

Last name _____ First name _____

Date of Birth ___ / ___ / ___ Social Security # _____

Measles (Rubeola)

Were you born before 1957? Yes No

Have you ever had Measles? Yes No

Measles Vaccination Dates ___ / ___ / ___ ___ / ___ / ___ ___ / ___ / ___

Tuberculosis (TB) Skin Testing

Have you ever had a TB skin test? Yes No

If so, were you told that the test was positive? Yes No

Have you ever been closely exposed to a person with TB? Yes No

Consent for Minors receiving TB Skin Test

I understand that if my son/daughter ever had a reaction to the TB Skin Test (PPD) they should not have this test done. I understand that if he/she has been exposed to a person with Tuberculosis within the last 10 weeks, I will contact Mercy Philadelphia Hospital, Employee Health Office. I understand that he/she cannot contract TB from having the skin test and there are no risks involved. I give my permission for the TB Skin Test (PPD).

Name of parent or gaurdian: _____ Date ___ / ___ / ___

Office Use Only

PPD placed on left/right forearm on ___ / ___ / ___ by _____

Results: ___ mm. Read on ___ / ___ / ___ by _____