Providence

COMMUNITY PARTNERSHIPS PROGRAM
HEALTH SCREENING DOCUMENTATION

_____ _____
Name **Date**

_____
School, Partner Agency, or Organization

Measles, Mumps, Rubella (MMR) Immunity

First Vaccination	Date:
Second Vaccination	Date:
OR	
MMR Titer Showing Immunity	Date:

Chicken Pox (Varicella) Immunity

First Vaccination	Date:
Second Vaccination	Date:
OR	
Varicella Titer Showing Immunity	Date:

Tuberculosis Screening – Date Must Be Within the Past 12 Months
PLEASE NOTE: A PPD skin test result is not acceptable.

Negative QuantiFERON-TB Gold Blood Test	Date:
OR	
Negative T-SPOT TB Blood Test	Date:
OR	
If positive TB test, medical clearance, including x-ray result, from within the past 12 months	Date:

COVID-19 Vaccinations

First Vaccination	Type:	Date:
Second Vaccination	Type:	Date:

_____ _____
Signature of Health Care Provider or School Nurse **Date**

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Printed Name of Health Care Provider or School Nurse