



UNIVERSITY *of* MOBILE

A HEALTHCARE PROVIDER'S SIGNATURE IS REQUIRED

Name: _____

Date of Birth: _____

MEASLES, MUMPS, and RUBELLA

Students must have received two doses of MMR vaccine **or** have serologic immunity to measles and rubella.

MMR vaccine: dose #1 ____ / ____ / ____ dose #2 ____ / ____ / ____

or

Date of Measles titer ____ / ____ / ____ *lab result must be attached Immune: Yes ____ No ____

Date of Rubella titer ____ / ____ / ____ *lab result must be attached Immune: Yes ____ No ____

TUBERCULOSIS SCREENING

Skin test placed: ____ / ____ / ____

Skin test read: ____ / ____ / ____

Results in millimeters: _____ mm

If test is positive

If test is positive, a copy of your chest x-ray must be attached

Prophylactic treatment for positive PPD: Yes ____ No ____

Treated with: _____ x _____ months

Completed treatment date: ____ / ____ / ____

I certify that the information above is complete and accurate to the best of my knowledge:

Healthcare Provider Printed Name _____ Date _____

Healthcare Provider Signature _____

Office Phone Number () _____

Office Address _____