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 _____

Revised 08/14/2017