Hennepin Technical College Dental Program Immunization Form - Fall 2020

Full Name:	Date of Birth:	HTC Student ID:

Dear Healthcare Provider,

This form, a requirement for entry into the **Dental Assistant** program at Hennepin Technical College, must be completed in its entirety, and signed by an MD, NP, or PA. These are the current CDC recommendations for immunizations for health care workers. **Printouts of clinic records cannot be accepted in place of this form.** Thank you for your assistance.

- Mumps immunity: Must have **ONE** of the following (check the appropriate box):
  □ Born before January 1st, 1957 ***OR***
  □ Vaccination after 12 months of age: Date of vaccination: ___________________ ***OR***
  □ Mumps titer indicating immunity: Date of titer* ___________________________
  **"Indeterminate" or "equivocal" levels of immunity upon testing should be considered non-immune.*

- Rubella (German Measles) immunity: Must have **ONE** of the following (check the appropriate box):
  □ Born before January 1st, 1957 ***OR***
  □ Vaccination after 12 months of age: Date of vaccination: ___________________ ***OR***
  □ Rubella titer indicating immunity: Date of titer* ___________________________
  **"Indeterminate" or "equivocal" levels of immunity upon testing should be considered non-immune.*

- Rubeola (Red Measles) immunity: Must have **ONE** of the following (check the appropriate box):
  □ Born before January 1st, 1957 ***OR***
  □ Vaccination with **TWO** doses after 12 months of age (at least 4 weeks apart):
  Date of 1st dose_________________ Date of 2nd dose ________________ ***OR***
  □ Rubeola titer indicating immunity: Date of titer* ____________________________
  **"Indeterminate" or "equivocal" levels of immunity upon testing should be considered non-immune.*

- Tetanus/diphtheria/pertusis (Tdap): **ALL must have the following:**
  □ One dose of Tdap after age 11: Date of vaccination*:_________________________
  **Tdap can now be administered regardless of interval since the last tetanus or diphtheria-toxoid containing vaccine.*

- Tetanus/diptheria booster (Td): (check the appropriate box):
  □ Td **only if more than 10 years** since receiving any type of Tetanus/diphtheria or Tetanus/diphtheria/pertussis vaccine.
  Date of most recent Td or Tdap :__________________ ***OR***
  □ Not applicable because a Td or Tdap or equivalent vaccine has been received within the last 10 years

- Hepatitis B 3-dose series: Must have **ONE** of the following (check the appropriate box):
  □ At least **two doses are needed for program admission** [the remaining dose can be completed after admission]
  Date of 1st dose (required)_____________ **Date of 2nd dose (required)**__________ [Date of 3rd dose_________]
  (For complete series: dose #1 now, dose #2 in 1 month, dose #3 approximately 5 months after 2nd dose) ***OR***
  □ Hepatitis B titer indicating immunity: Date of titer _____________________________

I certify this is an accurate record of the immunization history for the above-named student.
Signature of MD, NP, or PA* ___________________________________ Date______________
(**signature of a **primary care provider** is required. Note: A public health nurse may sign for county public health clinics)*

Medical exemption, if applicable: *The student is unable to receive the following immunization(s) due to a medical condition* ____
*Signature of MD, NP, or PA*_____________________________________*Date*________________