

**MILLCREEK COMMUNITY HOSPITAL
IMMUNIZATION REPORT**

NAME:	DOB:	SOCIAL SECURITY NO:
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1. Vaccines	Proof of Immunizations	
Diphtheria	Initial Series Dates	Date of Current
Tetanus	1. _____	Adult Tetanus
Pertussis	2. _____	1. _____
	3. _____	
	4. _____	

2. Chicken Pox	Date of Vaccine	Physician Documentation Date of Disease	Date of Pos. titer
1. _____	1. _____	1. _____	1. _____
	2. _____		

3. Polio	Initial Series Dates	Booster Date	Specify type: OPV or IPV
	1. _____	1. _____	1. _____
	2. _____		
	3. _____		

4. Rubeola	Initial Series Dates	Booster Date	2 doses if born after 1957
Mumps	1. _____	1. _____	
Rubella	2. _____	2. _____	1 dose if born before 1957
OR	3. _____	3. _____	
MMR	1. _____		
(2 doses)	2. _____		
OR			
Rubella Titer	And	Mumps Titer	And
Date of Titer _____		Date of Titer _____	
		Rubeola Titer	Date of Titer _____

5. PPD	Date	Results
Tuberculin	1. _____	_____

6. Hepatitis B	Series Dates	or	Positive Titer Date
Initial	1. _____		1. _____
1 Month	2. _____		
6 Months	3. _____		

As a licensed health care provider, I certify the above information is true and accurate to the best of my knowledge.

Name (Please Print)	Signature & Degree
	Date _____