Holsman Healthcare, LLC
Healthcare Staffing and Consulting Services
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Immunization & Vaccination Record

Name:

All travel healthcare staff must provide proof of immunity for Rubella, Rubeola, Mumps, Varicella, and Hepatitis B. In each section below, please select the appropriate information for your records. **All requested documentation must be included as noted for the selection to be valid and complete.** Any dates of immunizations must include month, date, and year.

MMR Screening (attach copies of actual vaccination documentation)

First MMR Date (mm/yyyy): _____/_____/_____

Second MMR Date (if born after 1957): _____/_____/_____

Rubella/German Measles (attach copies of lab results for titers)

☐ Receipt of live rubella vaccine (Date: _____/_____/_____)

☐ Rubella serology (Date of Titer: _____/_____/_____)

☐ Immune ☐ Not Immune

Mumps (attach copies of lab results for titers)

☐ Receipt of live mumps vaccine (Date: _____/_____/_____)

☐ Mumps serology (Date of Titer: _____/_____/_____)

☐ Immune ☐ Not Immune

☐ I choose to decline the mumps vaccination at this time. I accept I may be at risk of acquiring Mumps due to the occupational exposure of blood or other potentially infectious materials. _____ (Initials)

Rubeola / Measles (attach copies of lab results for titers)

☐ Receipt of live rubeola vaccine (Date: _____/_____/_____)

(Date of 2nd vaccination: _____/_____/_____)

☐ Rubeola serology (Date of Titer: ____/_____/_____)

☐ Immune ☐ Not Immune

Varicella Zoster / Chicken Pox Screening (attach copies of lab results for titers or documentation of vaccination)

☐ Receipt of live Varicella vaccine (Varivax) (Date: _____/_____/_____)

☐ Varicella serology (Date of Titer: _____/_____/_____) ☐ Immune ☐ Not Immune

☐ I have previous history of the Varicella disease and choose to decline the Varicella vaccinations or titer at this time. I accept I may be at risk of acquiring Varicella due to the occupational risks and exposures. _____ (initials)

Hepatitis B Vaccination / Screening (attach copies of lab results for titers and/or documentation of vaccination series)

☐ Three steps completed for HBV vaccine (Date of first step: _____/_____/_____)

(Date of second step: _____/_____/_____)

(Date of third step: _____/_____/_____)

☐ HBV surface antibody titer (Date of Titer: _____/_____/_____) ☐ Immune ☐ Not Immune

☐ I choose to decline the HBV vaccination at this time. I accept I may be at risk of acquiring Hepatitis B due to the occupational exposure of blood or other potentially infectious materials.

_____ _____

Signature Date

The above immunization and vaccination record is true and accurate to the best of my knowledge. I have attached all appropriate documentation to support any serology or vaccination selections. I certify that I have been given the general educational information and materials relating to blood borne pathogens that are required by OSHA regulations. I understand my assigned workplace will provide appropriate training and I will adhere to those policies and procedures of the facility. I accept I may be at risk of acquiring Hepatitis B due to the occupational exposure of blood or other potentially infectious materials and have been given the opportunity to be vaccinated by Holsman Healthcare at no cost to me while on active assignment. I agree to inform Holsman Healthcare of the decision at that time.

_____ _____

Signature Date