Anne Arundel Medical Center – Volunteer Immunization Form

Do not fill this form out on your own – it will only be accepted if signed by a health care provider.

Volunteer Name: _____ Date of Birth: _____ /_____ /_____

REQUIRED IMMUNIZATIONS		
Test	**Dates Given & Results**	**Notes**
Two-Step Mantoux Tuberculosis Tests **OR** **QuantiFERON-TB Gold** *(must be within the last 12 months)* Chest X-Ray *(only required if TB test is positive)*	TB Test #1 Date *(MM/DD/YY):* Given: _____ /_____ /_____ Read: _____ /_____ /_____ MM: _____ Result: POS _____ NEG _____ TB Test #2 Date *(MM/DD/YY):* Given: _____ /_____ /_____ Read: _____ /_____ /_____ MM: _____ Result: POS _____ NEG _____ Chest X-Ray *(MM/DD/YY):* Date Taken: _____ /_____ /_____ Result: POS _____ NEG _____	*Required for all volunteers*
MMR Vaccine Series or Titer	Date (MM/DD/YY): 1.) _____ /_____ /_____ 2.) _____ /_____ /_____ Titer: Date Drawn: _____ /_____ /_____ Result: POS _____ NEG _____	*Required for all volunteers*
Varicella Vaccine Series or Titer	Date *(MM/DD/YY):* 1.) _____ /_____ /_____ 2.) _____ /_____ /_____ Titer: Date Drawn: _____ /_____ /_____ Result: POS _____ NEG _____	*Required for all volunteers*
Flu Vaccine *(current year)*	Date *(MM/DD/YY):* 1.) _____ /_____ /_____	*Required yearly October-March for all volunteers*
Tdap *(must be within the last 10 years)*	Date *(MM/DD/YY):* 1.) _____ /_____ /_____	**Additionally required for clinical environments*
Hepatitis B Vaccine Series or Titer	Date (MM/DD/YY): 1.) _____ /_____ /_____ 2.) _____ /_____ /_____ 3.) _____ /_____ /_____ Titer: Date Drawn: _____ /_____ /_____ Result: POS _____ NEG _____	**Additionally required for clinical environments*

HEALTH CARE PROVIDER SIGNATURE (Dr., Nurse, NP, PA, DO)

This form will not be accepted if not signed by a health care provider.

Printed Name: _____ Phone: _____

Address: _____

Signature: _____ Date Completed: _____ /_____ /_____