



**Immunizations:**

MMR (date): \_\_\_\_\_

Tetanus Diptheria/TD (date): \_\_\_\_\_ (must be within 10 years)

Hepatitis B Series: #1 \_\_\_\_\_ (date)

#2 \_\_\_\_\_ (date)

#3 \_\_\_\_\_ (date)

\*Or signature on Hepatitis Declination Statement

Hepatitis B Titer: \_\_\_\_\_ (date) Hepatitis B Booster (if required): \_\_\_\_\_ (date)

**Diagnostic Tests:**

**Date**

**Results**

5 Panel Urine Drug Screen

\_\_\_\_\_

\_\_\_\_\_

Rubella Titer (or date  
Of last immunization)

\_\_\_\_\_

\_\_\_\_\_

Varicella Titer (or date  
Of last immunization)

\_\_\_\_\_

\_\_\_\_\_

PPD

\_\_\_\_\_

\_\_\_\_\_

\*Chest X-Ray

\_\_\_\_\_

\_\_\_\_\_

\*(Chest X-Ray is required as a follow-up for positive PPD results. After chest X-Ray has been completed, the individual must have regular physical examinations to monitor health status.)

Additional Comments/Recommendations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, this individual is in good physical and mental health.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Health Care Examiner

\_\_\_\_\_  
PRINT name of Health Care Examiner

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Telephone #

**HEALTH CAREER INSTITUTE**  
1926 10<sup>TH</sup> AVE N SUITE 405  
LAKE WORTH FL 33461