TidalHealth Volunteers

Immunization Record for Volunteers

Name: _____ **Date of Birth:** _____

Please provide a copy of your immunization record by either method below:

- ☐ Have a Licensed Provider complete ***and*** sign this form below

  OR

- ☐ Attach a copy of your immunization record to this form in lieu of a Licensed Provider's Signature

Dates of Mandatory Immunizations

MMR (*measles, mumps, rubella*): 1) _____ 2) _____

Titer Date: _____ Immune: _____ ***OR*** Not Immune: _____

Varicella (*Chicken Pox*) Vaccine: 1) _____ 2) _____

Titer Date: _____ Immune: _____ ***OR*** Not Immune: _____

Flu Shot Date: *(Applies during Flu Season only, October- March):* _____

Provider Name (*print*): _____

Address: _____

Provider's Signature: _____ **Date:** _____

Tuberculosis Questionnaire

Do you persistently have any of the following symptoms of tuberculosis?

Symptom	Yes	No
Persistent cough for more than 2 weeks		
Bloody Sputum production		
Unexplained weight loss		
Fatigue (unusual)		
Swollen glands		

THIS FORM AND ATTACHMENTS CAN BE RETURNED BY

EMAIL: kelly.novak@tidalhealth.org **FAX:** (410)-677-6644

MAIL: TidalHealth Volunteers • 100 E. Carroll St • Salisbury, MD 21801