TidalHealth Volunteers
Immunization Record for Volunteers

Name: _____

Date of Birth: _____ **TidalHealth badge #:** _____

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):* _____
COVID-19 Vaccination: 1) _____ 2) _____

Tuberculosis questionnaire

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

Symptom	Yes	No
Persistent cough for > 2 weeks		
Bloody sputum production		
Unexplained weight loss		
Fatigue (unusual)		
Swollen glands		
Poor appetite		
Have you had a positive TB skin test?		

Provider name (print): _____

Address: _____

Provider's signature: _____ **Date:** _____

Cleared for volunteering

Employee Health nurse: _____ **Date:** _____

This form and attachments can be returned by:
Email: volunteers@tidalhealth.org Fax: 410-677-6644
Mail: TidalHealth Volunteers 100 East Carroll Street, Salisbury, MD 21801