Ascension

Print Name of Volunteer Applicant:	DOB:
Social Security Number:	Phone:

The following MUST be completed by a physician, physician's assistant, or nurse practitioner. Please use mm/dd/yyyy format for dates.

Measles (Rubeola)	
2 doses of measles vaccine on or after their 1st birthday and at least 30 days apart OR	Date #1: _____ Date #2: _____
Serologic test positive for measles antibody	Date: _____ Result: _____
Mumps	
2 doses of mumps vaccine on or after their 1st birthday and at least 30 days apart OR	Date #1: _____ Date #2: _____
Serologic test positive for mumps antibody	Date: _____ Result: _____
Rubella	
1 dose of Rubella vaccine on or after their 1st birthday	Date #1: _____ Date #2: _____
Serologic test positive for Rubella antibody	Date: _____ Result: _____
Varicella	
2 doses of varicella vaccine on or after their 1st birthday and at least 30 days apart OR	Date #1: _____ Date #2: _____
Serologic test positive for Varicella antibody OR	Date: _____ Result: _____
Physician documented history or diagnosis of Varicella	Date disease occurred: _____
Tetanus, Diphtheria, Pertussis (Tdap)	
1 dose of TDaP vaccine within the last 10 years	Date: _____
Tuberculosis and Flu Vaccination Information	
Tuberculosis Blood Test: Must be completed **within 3 months prior** to starting to volunteer. Chest X-rays for positive blood test must be done within the last 90 days prior to starting to volunteer.	Date: _____ Type: ▢ Tspot **OR** ▢ QFT Result: ▢ Positive ▢ Negative **CXR Results for positive TB blood test:** Date: _____ Result: ▢ Positive ▢ Negative
Flu Vaccine (required during flu season)	Date: _____

Physician or Approved Licensed Health Professional Information	
Printed Name: _____ **Title:** _____	**Office/Clinic Stamp:**
Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____	
Signature: _____ **Date:** _____	