Boston Children's Hospital
Until every child is well™

Associated Personnel Immunization History

Section I: To Be Completed By Individual

LAST NAME	FIRST NAME	M	DATE OF BIRTH	BCH ID #	TITLE WITH BCH	START DATE	END DATE

1) Immunization requirements are role-specific. The immunization requirements for your role are included in the body of the email that included this form. Provide both the email and this form to your healthcare provider who should complete and sign section II.
2) Section II must be completed by your healthcare provider who can attest to your immunization. If there is a single provider that can be notated in the gray boxes. If there are multiple providers that should be notated in the "Administered By" field associated with the specific immunization.
3) Use this form rather than sending your entire health record as that would include HIPAA-protected information.
4) You or your healthcare provider should send the completed and signed form to AP_OHS2@childrens.harvard.edu
5) **DO NOT** submit this form without your Boston Children's Hospital ID Number which you will receive from your department.
6) All questions should be directed to Occupational Health Services at 857-218-3046 (Internally X 8-3046).

Section II: To Be Completed By Your Health Provider

NAME OF PROVIDER OF IMMUNIZATION HISTORY	PROVIDER'S SIGNATURE	DATE	PROVIDER'S PHONE

The highlighted areas reflect the immunization requirements for this individual. Questions can be directed to Boston Children's Hospital Occupational Health Department at 857-218-3046

Vaccine	Type	Date Given/or of Result	Administered or Attested By (Clinic, doctor, phone #) IF different from above		Vaccine	Type	Date Given/or of Result	Administered or Attested By (Clinic, doctor, phone #) IF different from above
Measles Vaccine or MMR Two dose given after 12 months of age OR positive antibody titer	1st Dose				**Varicella Vaccine** Two doses of Vaccine OR positive titer	1st Dose		
	2nd Dose					2nd Dose		
	OR Positive Titer Result					**OR** Positive Titer Result		
Mumps Vaccine or MMR Two dose given after 12 months of age OR positive antibody titer	1st Dose				**Hepatitis B** Series of three vaccines OR positive titer OR written declination	1st Dose		
	2nd Dose					2st Dose		
	OR Positive Titer Result					3rd Dose		
Rubella Vaccine or MMR One dose given after 12 months of age OR positive antibody titer	1st Dose					**OR** Positive Titer Result		
	OR Positive Titer Result					If you choose to provide a written declination, you must use the BCH Hepatitis B Vaccine Statement/Consent form. Check this box ☐ to indicate your intent and the form will be emailed to you.		
TB 2 Step Written Documentation Two TB Skin tests within one year including one within last 90 days OR two consecutive annual test over two years including one within last 90 days OR Negative IGRA test such as T-Spot OR Quantiferon Gold within last 90 days	1st TST Date Admin	TST Date Read	Results (mm)	Admin or Attested By				
	2nd TST Date Admin	TST Date Read	Results (mm)	Admin or Attested By	**Influenza Vaccine** If start date is between Oct 1st and March 31st	Influenza Vaccine		
	2nd TST tests must always be completed within last 90 days				**TDap** Recommended, not required	TDap Vaccine		
	OR Negative IGRA Test							
	OR IF history of positive TB test: Provide documentation of positive test, **PLUS** negative chest x-rays, **PLUS** attached documentation of treatment or counseling for LTBI, **PLUS** attached complete symptoms analysis from treating clinician							