

# Risk Management/ Required Immunizations Form

STUDENT NAME:			
	DATE	RESULTS	EXPIRES
IMMUNIZATIONS (* = Titer may be completed to show immunity)			
*Measles/Rubella (MMR) 1			
*Measles/Rubella (MMR) 2			
*2 Step Tuberculosis (PPD/Quantiferon/X-Ray)			
*2 Step Tuberculosis (PPD/Quantiferon/X-Ray)			
*Tdap (Adult Tetanus/Diphtheria/Pertussis)			
*Varicella (Chicken Pox) 1			
*Varicella (Chicken Pox) 2			
*Hepatitis A			
*Hepatitis B			
1.			
2.			
3.			
Flu (Seasonal)			
OTHER IMMUNIZATIONS (If Required by Clinical Site)			
Polio			
Covid-19			
OTHER INFORMATION			
CPR			
Personal Health Insurance	Verification	Waiver	
Drug Screen			
Criminal Background Check			

<b>UVU OSHA/HIPPA/PPE Training</b>			
<b>I certify this information is correct and true according to information supplied by the above-named student and verified by documentation. Supporting documentation is on file at the institution and available upon request.</b>			

Director of Clinical Education

Date

### Student Emergency Information

Name:		
Address:		
City:	State :	Zip:
Home phone:		Cell phone:
Contact person (in case of an emergency):		
Relationship to student:		
Contact person's home phone:		Cell phone:

### Physician

Name/Facility:		
Address:		
City:	State:	Zip:
Facility phone:		

### Insurance Information

Name of carrier:	Policy #:	Expires:
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