UNIVERSITY *of* MISSOURI

SCHOOL OF HEALTH PROFESSIONS

DEPARTMENT OF CLINICAL & DIAGNOSTIC SCIENCES

Diagnostic Medical Ultrasound, Clinical Laboratory Science, Nuclear Medicine, Radiologic Science, Respiratory Therapy

CLINICAL IMMUNIZATIONS AUTHORIZATION FORM

This educational program involves patient contact – providing evidence of the following immunizations/screenings is a program requirement, as this evidence is required for access to patient care facilities (aka "clinical sites") involved in your training experiences. This form will help the admissions committee of your chosen program to know what your health profile status is prior to being interviewed.

Program:

☐ Clinical Lab Sciences ☐ Diagnostic Medical Ultrasound ☐ Nuclear Medicine

☐ Radiography ☐ Respiratory Therapy

Student Information

______________________________ (Student Name – First, Middle, Maiden, Last)

______________________________ (Student Number)

______________________________ (Date of Birth)

______________________________ (Phone Number including area code)

__________ (Last 4 of SSN)

Clinical Start Year & End Year: _______ to _______
(Year start professional phase to anticipated graduation year)

Health Information History

Please enter the dates for all previously completed immunizations in the spaces below. Submitted information will be sent to Student Health for compliance verification. Any missing requirements can then be communicated by Student Health with enough time to complete prior to beginning clinical rotations (should you be accepted into the program). Positive titers are accepted in lieu of immunizations if you have had the disease (e.g. chickenpox). The following immunizations will be required except those noted as optional.

Immunization	Date Completed
MMR #1 or + titer	
MMR #2	
MMR Booster in College (*optional*)	
Hep B #1	
Hep B #2	
Hep B #3	

Immunization	Date Completed
Hep A #1 (*optional*)	
Hep A #2 (*optional*)	
Varicella #1 or + titer	
Varicella #2	
Flu shot (within the last year)	
TDAP (within the last 10 yrs)	

Notes:

 continued on 2nd page

605 Lewis Hall, Columbia, MO 65211 Phone: (573) 882-8034 Fax: [573] 884-1490

To Teach. To Serve. To Discover.

Attach copies or scan and email your Original Health Documents (aka supporting documentation) verifying the immunization information recorded above for submission with the rest of your application packet. Acceptable Health Documents for documentation include:

- School immunization records
- Health department records
- Physician records
- Military immunization records
- Employer immunization records

If you do not have original health documents, you must have titers (a blood test for immunity) drawn for any missing documentation. Copies of Original Health Documents verifying titers and positive immunity status must be submitted in place of the immunization documents.

Authorization

I, (full name)________________________**, have read the above information and authorize the University of Missouri School of Health Professions' Clinical & Diagnostic Sciences Department to disclose and discuss the identified information with the University of Missouri's Student Health Center and/or assigned clinical sites. I understand that, by signing this document, I release and discharge The Curators of the University of Missouri and its School of Health Professions' Clinical & Diagnostic Sciences Department from any liability and will hold The Curators of the University of Missouri and its School of Health Professions' Clinical & Diagnostic Sciences Department harmless for any release made pursuant to this Authorization.**

You may revoke this Authorization in writing at any time, except to the extent that we have already released information in reliance with Authorization. Authorization will expire 2 years from date signed. Upon request, a copy of this Authorization will be provided to you after you sign it.

Applicant Signature ____ Date ________________________