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.

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)

_____ _____ Clinical Start Year & End Year: _____ to _____

(Phone Number including area code) (Last 4 of SSN) (Year start professional phase to anticipated graduation year)

Health Information

Enter the dates completed for each space below. Positive titers are accepted in lieu of immunizations if you have had the disease (e.g. chickenpox). The following immunizations and screenings will be required prior to starting the clinical phase of your program except those noted as optional.

This is not a "to-do" list. Complete the information as it currently stands. If you complete these too early, you may be required to do it again. All health information will be compiled and monitored by University of Missouri Student Health.

Immunization	Date Completed
MMR #1 or + titer	
MMR #2	
MMR Booster in College (*optional*)	
TDAP (within the last 10 yrs)	
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)	
Notes:	
Screening	**Date Completed**
TB Test (within the last year)	

Attach a copy of your original health documents verifying the immunization information recorded above. Health documents acceptable for documentation include:

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

Authorization

I, _____, 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 _____

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