



BENNINGTON RESCUE SQUAD
CLINICAL EXPERIENCE
MEDICAL / IMMUNIZATION RECORD

PROOF OF IMMUNIZATIONS

Last Name:	First Name:	Middle Initial:
Date of Birth:	Primary Healthcare Provider (HCP) Printed Name:	

I certify that to the best of my knowledge and assessment that this individual possesses enough strength, motor coordination, and manual dexterity to be able to:

1. Lift at least 200 pounds with the assistance of another individual.
2. Stand, carry, balance, and walk on uneven terrain.
3. Stoop, kneel, climb, crouch, and crawl as needed to reach patients and safely remove/transport them.
4. Carry and utilize emergency medical equipment appropriately.

Immunization	Requirement	Dates
--------------	-------------	-------

MMR (measles, mumps, rubella)	2 vaccinations OR Positive antibody titer	MMR #1: ___/___/___ MMR #2: ___/___/___ OR Titer: ___/___/___
PPD (tuberculosis skin test)	2-step test 1-3 weeks apart (must be within 90 days of clinical experience start date) OR <u>If known positive test</u> , clear chest x-ray results	PPD #1: + - ___/___/___ PPD #2: + - ___/___/___ OR CXR: ___/___/___
Varicella	2 vaccinations OR Positive antibody titer OR Documentation of disease by HCP	Varicella #1: ___/___/___ Varicella #2: ___/___/___ OR Titer: ___/___/___ OR Date of disease (mm/yy) ___/___
Influenza	Annual flu vaccine required	Flu shot: ___/___/___
Tdap (tetanus, diphtheria, pertussis)	Tdap booster within 10 years	Tdap: ___/___/___
Hepatitis B	3 vaccinations OR Positive antibody titer	Hep B #1: ___/___/___ Hep B #2: ___/___/___ Hep B #3: ___/___/___ OR Titer: ___/___/___

Healthcare provider signature	Title	Date
-------------------------------	-------	------