Fast Response
School of Health Care Education

Required Immunizations and Tests for EMT Students

Name: _____

Please place a check in the appropriate box for each disease and fill in the information requested. The parties with which Fast Response is contracted for clinical and field externships require this information. The time restrictions and number of shots/tests is not negotiable due to these agreements. Incomplete or improper forms will not be accepted.

THIS FORM MUST BE COMPLETED BY A LICENSED PHYSICIAN OR NURSE **ONLY**.

Measles (Rubeola)

☐ Received first vaccine on _____ **-AND-** second vaccine on _____.

☐ Titer found to be positive on _____.

Mumps

☐ Received first vaccine on _____ **-AND-** second vaccine on _____.

☐ Titer found to be positive on _____.

Rubella

☐ Received first vaccine on _____ **-AND-** second vaccine on _____.

☐ Titer found to be positive on _____.

Tuberculosis #1 (Valid only if done within the last 12 months)

☐ **First** PPD Skin Test found to be negative on _____. (Second test required)

☐ Based on a positive PPD Skin Test, a chest x-ray was done and found to be negative for Tuberculosis on _____.

Tuberculosis #2 (Valid only if done within the last 3 months)

☐ Second PPD Skin Test found to be negative on _____.

FAST RESPONSE SAFETY TRAINING CENTER, INC.
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Tetanus (Valid only if done within the last 8 years)

☐ Received last vaccine on _____.

Hepatitis B (Blood test required)

☐ Titer found to be _____ on _____.

Influenza Vaccine (Valid only if completed during current season)

☐ Received last vaccine on _____.

Varicella Zoster (Chicken Pox)

☐ Received first vaccine on _____ **-AND-** second vaccine on _____.

☐ Titer found to be positive on _____.

By signing this form, the person below states that he/she is a physician or nurse and that the information contained in this form is correct and accurate to the best of his/her knowledge.

Signature of Reviewing Medical Personnel: _____
(Physician or Nurse)

Date: _____

Name of Reviewing Medical Personnel (Print or Type): _____

Name of Facility: _____

Address: _____

Telephone Number: _____

If the Reviewing Medical Personnel have any questions about this form or the student's immunization requirements, please feel free to call the Registrar at (510) 809-3652 or the student's Program Coordinator at the number listed below.