To: Connecticut Children's Volunteers

Volunteers Re: Immunization Documentation

Complete the requested information below and also attach a signed copy of your immunization record from your Physician's Office. *PLEASE DO NOT WRITE "SEE ATTACHED" IN LIEU OF COMPLETING THE FORM.

Volunteer Name (print):_____ **Date of Birth**: _____

If you **do not** have a record of your immunizations, you many have your physician complete this form. It must include the physician signature, mailing address and phone number.

In the event that vaccination records are unavailable or immunity has not been verified through titers, you must be vaccinated prior to volunteering at Connecticut Children's

MMR (Measles, Mumps and Rubella) **Two doses OR evidence of positive titer is required for all volunteers born on or after January 1, 1957** (Titer testing or vaccine if necessary, must be obtained through a private physician at the expense of applicant).

Date MMR #1 _____ Date MMR #2 _____ **OR** Date of positive titer _____

VARICELLA (Chickenpox) **History of disease OR 2 doses of vaccine OR evidence of positive titer required** (Titer testing or vaccine if necessary, must be obtained through a private physician at the expense of applicant).

Date of disease _____ **OR** Dates of immunization #1_____ #2_____ **OR** Date of positive titer _____

Tuberculosis (TB) **Verification of a 2-step PPD Skin Test OR a QuantiFERON Gold Blood test**

PPD #1
Date Placed _____ Date Read _____ Results _____

PPD #2
Date Placed _____ Date Read _____ Results _____

QuantiFERON-TB Gold test result: _____ Date: _____

If TB skin test is positive (or volunteer has a history of a positive test or vaccination with BCG):

If QuantiFERON or TB test is positive: Chest X-ray result: _____ Date: _____

If Chest X-ray is positive: Date treatment completed: _____

Tdap (Tetanus, diphtheria, and pertussis) **Must be from within the past 10 years**

Date of Tdap: _____

FLU SHOTS (MANDATORY during Flu Season)

Volunteers will be required to show documentation during flu season (generally October – May)

Today's Date: _____ Date of last flu shot:_____

COVID- 19 Vaccination (Highly Recommended)

1st Dose COVID-19 Date: _____ 2nd Dose COVID-19 Date: _____ Booster Date: _____ Bivalent Booster Date: _____

If completed by Physician:

Physician Name: _____ Phone: _____

Signature: _____ Date: _____