

Dalton State College  
**Associate of Applied Science Degree in Respiratory Therapy Technology**  
Student Immunization and Medical Record

**Part A: To be completed by applicant**

Date \_\_\_\_\_

Name \_\_\_\_\_  
First, Middle Initial, Last

Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street and Number or PO Box

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Health Insurance Company \_\_\_\_\_ Person Insured \_\_\_\_\_

Phone Numbers: Home: \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**Part B: To be completed by a physician or Health Department official:**

1. MMR (Measles, Mumps, Rubella) \_\_\_\_\_  
OR  
Measles \_\_\_\_\_ (Not required if born before 1957)  
AND  
Mumps \_\_\_\_\_ (Not required if born before 1957)  
AND  
Rubella \_\_\_\_\_

2. PPD 5TU \_\_\_\_\_ Results \_\_\_\_\_  
If positive,  
Chest x-ray \_\_\_\_\_ Results \_\_\_\_\_

3. DPT/DT (minimum 4) Last Boost \_\_\_\_\_

4. Hepatitis B (3 required) Note: Hepatitis B vaccine is not required for program admssion,  
but is required prior to clinical assignment.  
A. \_\_\_\_\_ B. \_\_\_\_\_ C. \_\_\_\_\_

If over one (1) year since series completion, Hepatitis Antibody Titer \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician or Health Department Official

\_\_\_\_\_  
Date