IOWA WESTERN   The world is waiting

Phlebotomy Training

This form **MUST** be returned to:

Iowa Western
Continuing Health Education
Looft Hall, Room 110
2700 College Road
Council Bluffs IA 51503

TO BE COMPLETED BY THE STUDENT (Please print clearly)

Name: ____
Last   First   Middle

Address: ____
Street/P.O. Box

____
City   State   Zip

Phone: ____________________ Email ____________________________

Fall/Spring/Summer 20____

Citizen: ❒ US   ❒ Other (Specify)____________________________

Student ID (SS#)

Date of Birth

Month   Day   Year

REQUIRED IMMUNIZATIONS

Must be completed and signed by your healthcare provider

MMR (Measles, Mumps, Rubella) (two doses required for students born in 1957 or later)

❒ a. Dose 1 given at age 12-15 months or later ....#1 ___/___/_____
M D Y

Dose 2 given at age 4-6 or later, and at least one month after the first dose ....#2 ___/___/_____
OR
M D Y

❒ b. Laboratory/serologic evidence of immunity (*attach copy of lab report*) .... ___/___/_____
M D Y

Tuberculosis Screening

❒ a. **2-Step TST:**

Date given ___/___/______   Date read ___/____/______

Date given ___/___/______   Date read ___/____/______

Result _______________ (Record actual mm of induration, transverse diameter; if no induration, write “0”)

Interpretation (based on mm if induration as well as risk factors) Positive _____   Negative _____

❒ b. **Chest x-ray** (required if tuberculin skin test is positive) result: Normal _____   Abnormal _____

Date of chest x-ray ___/____/______ *Attach copy of chest x-ray report*

Please contact the office of Continuing Health Education with any questions:
Office Hours: Monday – Friday 8 a.m. – 4:30 p.m.
ceh@iwcc.edu | 800.432.5852 or 712.325.3265 | **iwcc.edu/continuing_education**

IOWA WESTERN

REQUIRED IMMUNIZATIONS

Must be completed and signed by your healthcare provider

Hepatitis B—Required for all students. (Three doses of vaccine or a positive Hepatitis B surface antibody)

❐ 3 dose Hepatitis B series

Date #1 ___/____/_____ #2 ___/____/_____ #3 ___/____/_____ **OR**

❐ 3 dose combined Hepatitis A and Hepatitis B series

Date #1 ___/____/_____ #2 ___/____/_____ #3 ___/____/_____ **OR**

❐ Laboratory/serologic evidence of immunity or prior infection (*attach copy of lab report*) ___/___/_____
M D Y

Varicella (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 years)

❐ History of Disease verified by undersigned clinician .... Disease date ___/____/_____ **OR**

❐ Laboratory/serologic evidence of immunity (attach copy lab report) ___/___/_____
M D Y

❐ 1 dose given at 12 months of age or later but before the student's 13th birthday. Date of shot ___/____/_____ **OR**

❐ 2 doses. Dose 1 given after student's 13th birthday. 2nd dose at least one month after first dose

Date #1 ___/____/_____ Date #2 ___/____/_____

Tetanus-Diphtheria-Pertussis (Primary series with DTaP, DTP, DT, or Td, and booster with Td or Tdap in the last ten years). **If students have not had Tdap as an adult, they are required to get one dose**.

❐ Primary series of four doses with DTap, DTP, DT or Td

Date #1 ___/____/_____ #2 ___/____/_____ #3 ___/____/_____ #4 ___/____/_____

❐ Booster: Tdap (preferred) .... Date ___/____/_____

Healthcare Provider (Signature or stamp required)

Name (Print)_________________________________ Signature___________________________________

Address ____

City ____ State ______________ Zip __________________

Phone _______________________________________ Date _____________________________________