

APPENDIX A
JOB CORPS IMMUNIZATION FORMS

JOB CORPS IMMUNIZATION RECORD

Name _____ Center _____

DOB _____ DOE _____ ID Number _____

Before administering any vaccines, give copies of all pertinent Vaccine Information Statements (VISs) to students 18 or older, or mail to minor students' parent or legal representative.

Vaccine	Date Given (m/d/y)	Vaccine Site*	Vaccine			Vaccine Information Statement (VIS)		Vaccinator Signature
			Mfr.	Lot #	Exp. Date	Date on VIS**	Date Given**	
Tetanus-Diphtheria Toxoid-Adult (Td) <i>or</i>								
Tetanus-diphtheria-acellular pertussis (Tdap)								
Inactivated Poliovirus Vaccine (IPV) – age <18								
Measles/Mumps/Rubella (MMR)	1							
	2							
Hepatitis B Vaccine (HBV)	1							
	2							
	3							
Meningococcal conjugate vaccine (MCV4)	1							
	2							
Varicella	1							
	2							

REACTIONS (use reverse as needed):

*RA (right arm), LA (left arm), RT (right thigh), LT (left thigh), or IN (intranasal).

**Record the publication date of each VIS as well as the date the VIS is given to the student.

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Vaccine	Date Given (m/d/y)	Vaccine Site*	Vaccine			Vaccine Information Statement (VIS)		Vaccinator Signature
			Mfr.	Lot #	Exp. Date	Date on VIS**	Date Given**	
Hepatitis A (HAV)	1							
	2							
Human papillomavirus vaccine (HPV4)	1							
	2							
	3							
Influenza	1 st yr							
	2 nd yr							
Others:								

REACTIONS (use reverse as needed):

*RA (right arm), LA (left arm), RT (right thigh), LT (left thigh), or IN (intranasal).

**Record the publication date of each VIS as well as the date the VIS is given to the student.

PPD TESTING

Name _____ Center _____

DOB _____ DOE _____ ID Number _____

- Has student ever had:
1. Positive PPD skin test _____ Date (Month/Year)
 2. IGRA blood test: _____ Date/Result (+/-)
 3. Initial chest x-ray: _____ Date/Result (+/-)
 4. Treatment with INH: _____ Date/Duration (Months)

Date	Manufacturer Lot Number Expiration Date	Dose/Strength Route Injection Site	Signature	Date Read	Signature	Induration in Millimeters
						MM
						MM

Date of chest x-ray and results: _____

Date of IGRA blood test (if performed) and results: _____

Date student started on preventive treatment: _____

Reason student declined preventive treatment: _____

Student signature

Date

- Note:** Read reaction in 48-72 hours after injection
 Measure only induration
 Record results in millimeters
 Record as positive or negative per CDC guidelines
 Interpret without regard to history of BCG vaccination

CLASSIFYING THE TUBERCULIN REACTION	
≥5mm is positive in:	<ul style="list-style-type: none"> • Students who are HIV positive • Students who have had close contacts with persons with infectious TB • Students who have a chest radiograph suggestive of previous TB • Students with clinical evidence of tuberculosis • Students who inject drugs
≥10mm is positive in:	<ul style="list-style-type: none"> • Students with certain medical conditions, excluding HIV infection • Foreign-born students from areas where TB is common • Medically underserved, low-income populations including high-risk racial and ethnic groups (including the homeless)
≥15mm is positive in:	<ul style="list-style-type: none"> • All students with no known risk factors for TB

ISONIAZID (INH) CHEMOPROPHYLAXIS

Name _____ Center _____

DOB _____ DOE _____ ID Number _____

Date INH started _____ Dosage/frequency: 300 mg daily **OR** 900 mg twice weekly

Date other Rx started _____ Name/dosage/frequency _____

MONTH/YEAR	WEEK OF (DATE) (INITIALS)				

Symptoms (e.g., fever/chills, fatigue, weakness, malaise, anorexia, stomach pain, nausea/vomiting, diarrhea, tingling/numbness fingers, dark urine/pale stools, yellowness of skin/eyes, rash/itching. Note below with the date of onset.)

Additional comments or tests ordered/results:

Date _____

Date _____

Date record closed _____

Reason for termination of chemoprophylaxis (check all that apply):

- Completed treatment
- Non-compliant
- Toxicity
- AWOL
- Separation
- Other

Moved/Forwarding Address: _____
