GREY COUNTY PARAMEDIC SERVICES

Vaccine Preventable Diseases – Physician Sign-off

Employee: _____ Oasis: _____

Date: _____

Disease Requirements	Date of Previous Immunization(s)	Date	Method to address Outstanding Requirements	Date of New Immunization	Date
Tetanus/Diphtheria (Td) (A primary Series of 3 doses, plus a booster every 10 years)	1st Dose		If no booster within 10 years, a series of 3 doses for Td are required	1st Dose	
	2nd Dose			2nd Dose	
	3rd Dose			3rd Dose	
	Booster				
Polio (A primary series of 3 doses) **IPV?**	1st Dose		If no previous immunization; a series of 3 doses for Polio are required	1st Dose	
	2nd Dose			2nd Dose	
	3rd Dose			3rd Dose	
Pertussis (Tdap) (Single dose required)	1 Dose		If no previous immunization; 1 dose of Tdap is required	1 Dose	
Varicella (A series of 2 doses, documented diagnosis or verification of Varicella or immunity via serology submission)	1st Dose		If no documented history of varicella, or serology results confirming immunity or 2 dose series; a series of 2 doses for varicella are required	1st Dose	
	2nd Dose				
	Varicella confirmation			2nd Dose	
	Serology results				
Measles (A series of 2 doses or immunity via serology submission)	1st Dose		If no previous immunization or serology results; a series of 2 doses for measles are required	1st Dose	
	2nd Dose				
	Serology results			2nd Dose	
Mumps (A series of 2 doses or immunity via serology submission)	1st Dose		If no previous immunization or serology results; a series of 2 doses for mumps are required	1st Dose	
	2nd Dose				
	Serology Results			2nd Dose	

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Rubella (Two doses or immunity via serology submission)	1st Dose		If no previous immunization or serology results; 1 dose of rubella is required	1 Dose	
	2nd Dose				
	Serology results				
Hepatitis B (A 2 – 4 dose series with serology testing within 1-6 months to confirm immunity)	1st Dose		If no evidence of immunity via serology testing; a series of 3 doses and serology testing within 1-6 months is required	1st Dose	
	2nd Dose			2nd Dose	
	3rd Dose			3rd Dose	
	4th Dose			Serology Results	
	Serology results				

I, hereby, certify that the above information to be factual to the best of my knowledge.

Physician name: _____ Date: _____

Physician Signature: _____