**Portland Community College – Dental Assisting Program**
**VACCINATION HISTORY FORM**

**Please complete this form and send to the Dental Sciences Department with your completed application.**

Student Name: ____________________________________________________

| | | | |
|---|---|---|---|
| Hepatitis B vaccine dates: | 1) ____________ Date of 1st injection | 2) ____________ Date of 2nd injection | 3) ____________ Date of 3rd injection |
| Titer: | Date: _________ | Results: _________ | |
| Measles, Mumps, Rubella or combinations | Date: | 1) ____________ | |
| *OR* Antibody Test | Date: _________ | Results: _________ | |
| Td date: (Tetanus/Diptheria) | 1) ___________ (within last 10 years) | | |
| Varicella Zoster date: (chicken pox) | 1) ___________ | | |
| *OR* Date of Disease | Date: ________ | | |
| *OR* Antibody Test | Date:_________ | Results: ________ | |
| TB Screening *OR* Chest X-ray | Date: _________ | Results: _________ (within last year) | |
| CPR Card | Expiration Date: ________ | | |
| Copy of front and back of card must accompany this form / expires no earlier than June 30 of graduating year. *See CPR requirements list. | | | |

Students may decline the HBV vaccine but must sign the formal declination form on the back of this page.

I hereby verify that all information entered on this form is true and can be verified by a medical care provider. I grant permission for Portland Community College to release this information to a clinical education facility if requested as part of my student records. If any of the above information is false, dismissal from the program will occur.

Student Signature_____________________________________ Date __________________

*Please return to:* Dental Sciences Department
PCC SY HT 206, PO Box 19000
Portland, OR 97280-0990