Bay Area Training Academy

Name: _____

Bay Area Training Academy Required Immunizations and Tests for E.M.T. Students

Please place a check in the appropriate box for each disease and fill in the information requested. Incomplete or improperly completed forms will be returned to the above student. The parties that the Bay Area Training Academy E.M.S. program has contracted with for clinical and field experiences require this information. The dates or number of immunizations is not negotiable due to these contracts. All dates are based on the last date of the semester to ensure that the Bay Area Training Academy E.M.S. Program is in compliance with the contracts. Each disease must have at least one box checked.

Measles, Mumps, Rubella (MMR)

- ○ Measles (Rubella) Titer found to be positive on (MM/DD/YY)_____.
- ○ Mumps Titer found to be positive on (MM/DD/YY)_____.
- ○ Rubella Titer found to be positive on (MM/DD/YY)_____.

If any of the three titers were not positive and/or not done,

- ○ Received last MMR vaccine on (MM/DD/YY)_____.

Tuberculosis (Valid Within the Last 3 Months OR)

- ○ Currently under treatment for Tuberculosis and is not infectious.
- ○ PPD Skin Test or Blood Test found to be negative on (MM/DD/YY) _____.
- ○ Based on a positive PPD Skin Test, a chest x-ray was done and found to be negative for Tuberculosis on_____.

Tetanus (Within 10 Years)

- ○ Received last Tdap vaccine on (MM/DD/YY)_____.

Tel: 800.701.7333 | Fax: 510.614.1429
14275 Wicks blvd., San Leandro, CA 94577
BATAeducation.com

Bay Area Training Academy

Varicella Zoster (Chicken Pox)
○ Varicella Zoster Titer found to be positive on (MM/DD/YY)_____.
○ Received last Varicella vaccine on (MM/DD/YY)_____.

Hepatitis B (Valid only if series completed, currently in progress, has immunity)
○ Received Hepatitis vaccines:
○ 1st vaccine was given on (MM/DD/YY)_____.
○ 2nd vaccine was given on (MM/DD/YY)_____.
○ The last vaccine was given on (MM/DD/YY)_____.
○ Hepatitis B Titer found to be positive on (MM/DD/YY)_____.

By signing this form, the person below states that he/she is a physician or nurse and that the information contained in this form is correct and accurate to the best of his/her knowledge.

Signature of Reviewing Medical Personnel (Physician or Nurse) _____
Date: _____

Name of Reviewing Medical Personnel (Print or Type): _____
Address: _____
Telephone Number: _____

If the Reviewing Medical Personnel has any questions about this form or the medical requirement needed by the student for this program, please feel free to call Nicky Bahr at 949-899-3363.