



CRITI CARE EMS IMMUNIZATION FORM

CRITI CARE, INC
Emergency Medical Services
EMS Education Services
Paramedic Academy

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Student Name (please print) _____

Mailing Address _____

City _____ Province _____ Postal Code _____

Date of Birth (dd/mm/yy) _____ / _____ / _____

Verification of either inoculation for the following OR laboratory testing confirming the presence of antibodies specific to the following diseases that would render appropriate immunity

MMR (Measles, Mumps, Rubella)

Td (Tetanus and Diphtheria)

VARICELLA (Chicken Pox)

HBV (Hepatitis B Vaccine) OR Hepatitis A & B Vaccine Combination

➤ Initial Injection Date: _____

➤ 1 Month Follow Up Dose Date: _____

➤ 5 – 6 Month Final Booster Date: _____

Confirmation of either

Negative 2 Step PPD (Mantoux) skin test for Tuberculosis

Negative Chest X-ray for Tuberculosis (developed < 1 year ago)

Physician's Name

Physician's Signature

Date of Affirmation

Name of Facility/Clinic