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Name

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Facility Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Signature (Please stamp or print legibly)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact number Date

**I give my employer permission to release my health information as listed below:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_**

Signature of permission Date

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Requirement** | **Date of administration** | **Boosters** | **Titer or blood test result** | **Renewal** | **Notes** |
| Physical Exam |  |  |  |  |  |
| Chickenpox Vaccinations (2) or titer |  |  |  |  |  |
| MMR (2) |  |  |  |  |  |
| Tdap and Td |  |  |  |  |  |
| Hep B |  |  |  |  |  |
| TB (Mantoux/ x-ray or blood test) |  |  |  |  |  |
| Influenza (flu) |  |  |  |  |  |