



**Standard Vaccine Form**  
*For Respiratory Therapy Technology Program*

Name of Applicant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Vaccine Form:** Must be completed and initialed by a physician or trained medical personnel under the supervision of a physician.

Has the applicant had:		Initials
<b>Rubella Vaccine</b>		
Yes	Date(s) of immunization:	
<b>A titer is required regardless of immunization status</b>	<b>Date of titer:</b>	<b>Results of titer</b>
<b>Measles (Rubeola) Vaccine</b>		
Yes	Record dates of 2 live immunizations after 1 <sup>st</sup> birthday	
No/Unknown = titer required	Date of titer:	Results of titer (if required)
<b>Mumps Vaccine</b>		
Yes	Record dates of 2 live immunizations after 1 <sup>st</sup> birthday	
No/Unknown = titer required	Date of titer:	Results of titer (if required)
<b>Polio Vaccine</b>		
Yes	Date of immunization:	
No/Unknown = titer required	Date of titer:	Results of titer (if required)
<b>Chickenpox (Varicella)</b>		
Date of Vaccine or Date of Illness Required	Date of immunization:	
	Date of illness:	
<b>Tdap Vaccine <b>Within Last 7 Years</b></b>		
Yes	Date of immunization:	
No/Unknown/Outdated = booster required	Date of booster:	

**I certify that I am a licensed physician or work directly with a licensed physician.**

Print Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

*Signature* \_\_\_\_\_ *Date of Examination* \_\_\_\_\_

**\*\*\*Cost of the physical examination, laboratory tests, and immunizations assumed by the applicant. \*\*\***

**Students:**

**Submit this completed form to the Student Upload Portal found on the Respiratory Therapy webpage.**

**RETURN DOCUMENT TO STUDENT FOR DOCUMENT UPLOAD**

*Revised: November 2025*