



Emergency Medical Teaching Services, Inc.

201—205 Oak Street, Second Floor

Pembroke, Massachusetts 02359

Office: (877) 385-EMTS or (781) 826-2011 Fax: (781) 826-8812

Immunization Documentation Form

This form required within three (3) months after acceptance into the program.

Name _____

Address _____

City _____

State _____

Zip _____

Immunization Type

Current

Date of Immunization

Measles vaccine (after 1968)

Y / N

MMR (Measles, Mumps, Rubella)

Y / N

Tetanus/Diphtheria (within last 10 years)

Y / N

Mantoux test (tuberculin skin test) With a
 Negative result within the last six months

Y / N

Completion of the Hepatitis B Series

Y / N

Dose 1:

Dose 2:

Dose 3:

Varicella (Chicken Pox) Vaccine or Serological evi-
 dence of immunity or past Medical records indicating
 history

Y / N

You must have supporting documentation attached regarding your immunizations.

If a health care provider filled out this form, please complete the information below.

Health Care Provider _____

Health Care Organization or Affiliation _____

Address _____

City _____

State _____

Zip _____

Phone Number _____

Fax Number _____

Signature _____

Date _____