Immunization Record for Clinical Education Minnesota State University, Mankato M.S. in Athletic Training

Name:		
(Full legal name with middle initial)		(date of birth)
Immunization Record Verification : Minnesota Law (M.S. 135A.14) requires that all students born after 1956 and enrolled in a public or private post-secondary school in Minnesota be immunized against diphtheria, tetanus, measles, mumps, and rubella, allowing for certain specified exemptions. However, the athletic training program requires all athletic training students to maintain additional immunizations in compliance with clinical education site expectations. Documentation of vaccinations are required for final program admission and all athletic training students must provide documentation prior to starting required clinical experiences.		
Required Immunizations:		
MMR (Measles, Mumps, Rubella) [#]	Date of most recent dose:	
#Most recent dose required at or after 12 m	onths of age	
Tdap (Tetanus, diphtheria, pertussis) ¹ ¹ Most recent dose required within past 10	Date of most recent dose:	
TB screening/Mantoux (within 12 months)@	Date of screening:	
TB screening/Mantoux (within 12 months) [@] [@] Or evidence of recent chest x-ray or serologic	testing indicating the presence of antil	odies
Varicella (chicken pox)** ** Or evidence of serologic testing indicating the	Date of dose or titer: ne presence of antibodies.	
Hepatitis B* dose (final) 3 ** Or evidence of serologic testing indicating the	Date of final (3rd dose) or tit e presence of antibodies.	er:
Optional Immunization: SARS-COV-2 (COVID)	Date of final dose:	
**At this time the University and the program do n of fall semester. Students are strongly encouraged to seek a Medical Exemption documented by license Medical Exemption: The student named above lacks	COVID-19 vaccine at this time. d Physician, Nurse Practitio	oner, or Physician's Assistant
- a medical problem that precludes the	-	vaccine
- has not been immunized because of a history of		disease
- has laboratory evidence of immunity against		disease
Summary of defects and diagnosis:		
Drug Allergies (if applicable):		
Provider Signature & Date:		
Note that conscious exemption may preclude students from o student's ability to complete all program requirements.	obtaining some required clinical experie	ences, therefore will negatively impact the
To my knowledge the above information is accurate an	nd complete:	
Signature of Student	Date	
THIS FORM MUST BE COMPLETED AND SUB HEALTHCARE ORGANIZATION DETAILING		IMUNIZATION RECORD FROM A

Please return this completed form or direct questions to:

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