Central New Mexico Community College
School of Health Wellness and Public Safety - **Veterinary Technology Program**
Immunizations Documentation Form
PLEASE RETURN THIS FORM to the Veterinary Technology Clinical Coordinator by your *Due Date* _____

Health Care Resources for CNM Students: Contact your primary healthcare provider
OR
local Public Health Office (*if uninsured*)
Insurance Options: UNM Cares 1-888-453-1304, 272-2521. Insure New Mexico 1-888-997-2583
[STUDENTS – PLEASE MAKE A COPY OF THIS COMPLETED FORM FOR YOUR RECORDS.]

Name: First Middle Last	CNM Student ID#	
Address	Phone #	
Sex: _____M _____F	Birth date:	Program

REQUIRED IMMUNIZATIONS (LIST DATE LAST IMMUNIZED)
Tdap (Tetanus/Diptheria/Pertussis) Date_____ ***Tdap within the last 10 years** *
(This is the only **required** vaccination for the Veterinary Technology Program.
Please attach a copy of the immunization record / card/ certificate / invoice to this form.)

B. RECOMMENDED IMMUNIZATION:

Rabies Vaccination	#1_____ Date	#2_____ Date	#3_____ Date	Titer_____ Date

I understand that due to my occupational exposure to saliva or other potentially infectious materials, I may be at risk of exposure to Rabies. I decline Rabies vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Rabies, a serious and fatal disease.

_____
Waiver Signature

C. OPTIONAL IMMUNIZATIONS:
Since the Veterinary Technology Program is part of the "School of Health, Wellness and Public Safety"; the general health and wellbeing of each student is emphasized. If you have not had a recent physical, or if you have any questions regarding your ability to perform the physical requirements for the veterinary technology profession, please consider making an appointment with a healthcare provider. Other vaccinations that you may wish to discuss with your medical provider could include any / all of the following (if applicable, make note of previous vaccine dates):

MMR date_____ ***OR*** MMR Titer date _____ (immune) ☐ (non-immune) ☐
Tuberculin skin Test or "TB Gold" date_____ TB Results _____ date _____
If positive, chest x-ray recommended: date_____ X-ray results_____
Varicella (Chicken Pox) Titer date_____ (immune) ☐ (non-immune) ☐
or Varicella Immunization date_____
Hepatitis A #1 date_____ #2 date_____
Hepatitis B #1 date_____ #2 date_____ #3 date_____ Titer date:_____
Flu Vaccine (annual) date_____ Pneumonia Vaccine (after age 50) date_____

Student's Signature/Date _____

Practitioner's Signature/Date_____ **Practitioner's Last name printed:**_____

Facility:_____ **Facility Phone #:**_____

CNM School of Health, Wellness & Public Safety

Latex Allergy Assessment

(To be completed by the Student, who then discusses this with a health practitioner for their recommendations.)

Name_____ Date_____

1. After a medical or dental procedure, have you ever had any of the following
   a. Rash _____Yes _____No
   b. Hives _____Yes _____No
   c. Swelling _____Yes _____No
   d. Shortness of breath _____Yes _____No

2. Have you ever had a rash on your hands that lasted greater than a week? _____Yes _____No
   a. If yes, do you know what it was from?
   _____
   _____

3. After coming in contact with any latex or rubber product (e.g.: balloons, gloves, condom, diaphragms, etc.) have you experienced any of the following?
   a. Rash _____Yes _____No
   b. Hives _____Yes _____No
   c. Swelling _____Yes _____No
   d. Itching _____Yes _____No
   e. Runny nose _____Yes _____No
   f. Eye irritation _____Yes _____No
   g. Wheezing or asthma _____Yes _____No

4. Has a physician ever told you that you are allergic to rubber or latex? _____Yes _____No
   If yes, what kind of treatment did you receive?
   _____

5. Do you/did you use gloves or any rubber/latex product in previous occupation or jobs?
   _____Yes _____No
   If yes, what products were you exposed to?
   _____

6. Do you have any food allergies?
   _____Yes _____No

7. If yes, are you allergic to any of the following?

	Recent onset	long standing
Bananas	_____	_____
Avocados	_____	_____
Pineapple	_____	_____
Kiwis	_____	_____
Chestnuts	_____	_____
Passion Fruit	_____	_____
Other _____	_____	_____

   Describe the reaction:
   _____

8. Do you have any congenital abnormalities (spinabifida, Myeloma, Myelodysplasis)?
   Yes_____ No_____

9. Do you have history of the following?
   a. Contact dermatitis _____Yes _____No
   b. Asthma _____Yes _____No
   c. Hay fever _____Yes _____No
   d. Eczema _____Yes _____No
   e. Autoimmune disease _____Yes _____No

_____ _____

Student Signature/Date Physician signature/Date

Revised April 15, 2016