Academic Health Attestation Form

The purpose of this form is to collect and verify immunization records. This form should be completed and confirmed by a healthcare provider, pharmacy team member, or school health clinic team member. This form is required for onboarding at Children's Hospital Los Angeles.

STUDENT/OBSERVER NAME: _____**School**_____

Immunization Screening:

Please provide attestation as proof of records for the items listed below:

Tdap (Tetanus, Diphtheria, and Pertussis) Date of last Tdap

- Proof of Tdap vaccination with the last 10 years
- Td vaccines are not acceptable due to missing Pertussis (P) and protection needed for children

Measles, Mumps, Rubella (MMR): Date of vaccinations (1) _____, (2) _____ OR Positive titer date _____

- Two (2) MMR vaccinations at any age born after 1956
- Or serologic (antibody titers) evidence of immunity to MMR) date
- One time childhood vaccination

Varicella (Chickenpox): Date of vaccinations (1) _____, (2) _____ OR Positive titer _____

- Two (2) Varicella vaccination date
- Or serologic (antibody titer) evidence of immunity to Varicella
- Or date of written statement of diagnosis of having Chickenpox (Varicella) _____
- One time childhood vaccination

Tuberculosis (TB): Date PPD Read _____/Results Negative Or Date Neg.IGRA_____

- Tuberculin (TB) Test -Mantoux/PPD within 12 months prior to start date at CHLA
- Or IGRA blood test (QuantiFERON Gold or T-Spot) within 12 months prior to start date at CHLA
- Or, if skin-test positive, a written report of chest x-ray results taken within 12 months prior

Influenza (Flu Shot): (during respiratory season) Date _____

- One (1) flu vaccination only during flu season (November 1st – April 30th) annually
- If declining the influenza shot, please select a reason: Health Exemption

COVID-19: Date _____

- One (1) COVID-19 booster vaccination when eligible (during respiratory season November 1st – April 30th) annually
- If declining the COVID-19 shot, please select a reason: Health Exemption

I declare that the information provided is true and without omission to the best of my knowledge.

Validation of Records (Check one): ☐ Provider ☐ Pharmacy ☐ School

(Print) _____

Signature _____

Date _____

- **Note:** Validator of Records verifies the immunization records of the student/observer.

Academic Health Attestation/EHS Forms 06/2024