Eastern Michigan University
School of Health Promotion and Human Performance
Athletic Training Program

Name_____

Address_____

Email Address_____Phone number_____

Immunization	**Date of vaccination**
HBV	
Tuberculosis skin test [PPD negative]	
MMR	
Td (tetanus/diphtheria and or Tdap within the last 10 years)	
Varicella (chicken pox vaccine or history of the disease)	

Name of Physician_____**Phone number**_____

Signature of Physician_____**Date**_____