

**West Hills Hospital and Medical Center
New Volunteer Immunization History Form**

Volunteer Name: _____

Date of Birth: _____

Department: _____

Requirements for ALL NEW VOLUNTEERS

Immunization History

_____ **I was born PRIOR to 1957**

Please indicate below if you had any of the diseases listed. If you do not know the dates, just write "yes" in column instead of date.

_____ **I was born AFTER 1957**

Please complete the requested information below.

Disease/Vaccine	Year of Vaccine(s)	Year of Illness	Never Had
Rubella (German Measles)	#1:		
Rubeola (Hard Measles)			
Mumps		#2:	
Varicella (Chicken Pox)	#1:		
	#2:		
Hepatitis B			
Tetanus/Diphtheria (most recent)			
BCG Vaccine (foreign born)			
TB			
Other			