# THE UNIVERSITY OF KANSAS SCHOOL OF PHARMACY IMMUNIZATION AND INSURANCE INFORMATION – TO BE COMPLETED BY THE STUDENT

Student Name:

Health Insurance: Name of Company:
Group #:
ID #:

Liability Insurance: Name of Company:
Policy#:
Policy Dates:
Limits:

Liability policies must be minimum $1,000,000/incident and $3,000,000/aggregate.
****Please provide copies of your insurance cards and/or documentation**

In what state(s) are you licensed to practice Pharmacy and what are your pharmacy license numbers?
****Please provide copy of your current Pharmacy license**

State #1_____ License #_____

#2_____ _____

#3_____ _____

## Immunization Record: Provide **documentation** of each Immunization!

Send or FAX to NTPD office. Filling the date of completion in this form is not adequate documentation.

| Date | Results | Immunization |
|---|---|---|
| | | Measles, Mumps, Rubella Vaccine #1 |
| | | Measles, Mumps, Rubella Vaccine #2 |
| | - - - | Hepatitis B Vaccine #1 |
| | - - - | Hepatitis B Vaccine #2 |
| | - - - | Hepatitis B Vaccine #3 |
| | | Hepatitis B Titer (if negative, series & titer must be repeated) |
| | | Tuberculin Skin Test |
| | | Varicella zoster Vaccine or Titer |
| | | Tetanus/diphtheria (Td) |
| | - - - | CPR certification |
| | - - - | Signed Confidentiality Statement |

**All immunizations must be <u>complete</u> before enrolling or beginning any clerkship!**
**Additional information available online regarding immunizations

Signature of Pharmacy School Representative

_____