NDSU | Professional Athletic Training Program

MATrg Required Immunizations (2nd Year)

Applicant's Name _____

Date of Birth _____ NDSU ID #_____

***Documents from personal on-line medical chart or healthcare facility can replace this form.**

TB Test (submit copy of results)*

Name of Clinic _____

	Date	Negative/Positive	Signature (RN, CNP, etc.)
TB Test			

___Check if additional documentation is provided.

Varicella (Chicken Pox)*

Name of Clinic _____

	Date	Signature (RN, CNP, etc.)
Varicella		

___Check if additional documentation is provided.

Flu Shot (Influenza)*

Name of Clinic _____

	Date	Signature (RN, CNP, etc.)
Flu Shot		

___Check if additional documentation is provided.

Revised May 2017