The following documentation must be submitted with application for admission to the nursing program. Certain immunizations may be obtained through the Public Health Department, clinic, your MD or Student Health Services. Note: you must be currently enrolled & attending classes to use Student Health Services.

**NOTE: PLEASE ATTACH ANY SUPPORTING DOCUMENTATION TO THIS FORM.**

**HEPATITIS "B"**

Receipt of Hepatitis "B" vaccine – (series of three doses)

<table>
<thead>
<tr>
<th>Dates</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td></td>
</tr>
<tr>
<td>#2</td>
<td>(1 month after #1)</td>
</tr>
<tr>
<td>#3</td>
<td>(6 months after #1)</td>
</tr>
</tbody>
</table>

PLUS follow-up titre - after series is completed – confirming immunity.

<table>
<thead>
<tr>
<th>Date of Titre</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1 to 2 months after #3)</td>
</tr>
</tbody>
</table>

*Note: If negative or non-immune, the student must receive a Hepatitis B “booster”.

**RUBEOLA (MEASLES)**

**Students born in 1957 or later:**

Documented Seropositivity (Titre)  
Date: __________  Results: ________

OR

Documented receipt of two doses of a measles-containing vaccine received on or after the first birthday

Date: __________

**Students born before 1957:**

Documented Seropositivity (Titre)  
Date: __________  Results: ________

OR

Documented receipt of one dose of a measles-containing vaccine received on or after first birthday

Date: ________

**MUMPS**

Documented Seropositivity (Titre)  
Date: __________  Results: ________

OR

Documented receipt of one dose of a mumps vaccine received on or after first birthday

Date: ________
*RUBELLA (GERMAN MEASLES)

Documented Seropositivity (Titre)  Date: ________ Results: _______

OR

Documented receipt of one dose of a rubella-containing vaccine, received on or after first birthday  Date: ________

*Women pregnant when immunized or who become pregnant within three months of immunization should be aware that potential risks to the fetus may exist.

TETANUS-DIPHTHERIA ACELLULAR PERTUSSIS (Tdap) MUST be after 2005
(Booster every ten years)  Date: __________________________

VARICELLA (CHICKEN POX)

Documented seropositivity (Titre)  Date: ________ Results: _______

OR

Documented receipt of Varicella Vaccine(s)  Date(s): __________________________

(Note: If results are negative or non-immune, a series of two vaccinations are required)

#1 ____________________  #2__________________

ANNUAL TUBERCULIN SKIN TEST (TB skin test must be current and IN FILE throughout program)
DO NOT complete TB skin test for the application, complete after July 1st and submit before Fall semester.

Results: Negative ______________  *Positive ______________  Date Read: __________________________

*If positive: Chest X-Ray must be performed within 2 months of positive tuberculin skin test.

Chest X-ray Date ______________  Results: __________________________

(Note: Chest X-ray is required within 12 months of starting program)

FLU VACCINE
Flu Vaccine is required every year on separate Consortium Flu Documentation form which will be emailed to students in the Fall semester. Do not get flu vaccine until you have the form for documentation.

Signature of Physician or Nurse verifying accuracy of information.

_________________________________________________________  __________________________
Signature  Date

_________________________________________________________
Name/Address/Telephone # of Agency

DB:hr/StudentsForms/IMMUNIZATIONS-NEW STUDENTS 12/5/2012.