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)

Dates: #1 _____________
#2 _____________ (1 month after #1)
#3 _____________ (6 months after #1)
PLUS follow-up titre - after series is completed – confirming immunity.

Date of Titre: __________ Results: __________ (1 to 2 months after #3)

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

ANNUAL TUBERCULIN SKIN TEST (TB skin test must be current and IN FILE throughout program)

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)

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: _________

OR

Documented evidence of measles disease 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 _______________

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 9/5/2012.