Nursing Program – Immunization Record

(To be submitted with application to the major
or used to provide updated immunization
information while enrolled)

Name:_____ _____ _____
Last First Middle

Date of Birth:____/____/_____ University ID # _____

MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER

Required for all nursing students:

1. Tuberculosis Screening: Must fulfill either the skin testing or blood testing requirements and complete chest x-ray if either result is positive.

- Tuberculin Skin (Mantoux) Test: Must be placed and read in the United States for ALL students.
  - Two-Step: (Required for initial skin testing of adults who will be tested annually. Second test must be administered 1-3 weeks after the first.)

    First Test:

    Date Given:____/____/_____ Date Read:_____/____/_____ Results:_____mm

    Interpretation (based on mm of induration as well as risk factors):

    Single Positive: ☐ Negative: ☐

    Second Test:

    Date Given:____/____/_____ Date Read:_____/____/_____ Results:_____mm

    Interpretation (based on mm of induration as well as risk factors):

    Single Positive: ☐ Negative: ☐
  - Annual One-Step (If annual TB testing has been done, list the most recent.)

    Date Given:____/____/_____ Date Read:_____/____/_____ Results:_____mm

    Interpretation (based on mm of induration as well as risk factors):

    Single Positive: ☐ Negative: ☐
- Quantiferon-TB Gold or T-SPOT.TB Blood Test

  Results: Positive: ☐ Negative: ☐ Date of test:____/____/_____
- Chest X-Ray (Required if Tuberculin skin test or blood test is positive)

  Results: Normal: ☐ Abnormal: ☐ Date of chest x-ray:_____/____/_____

2. Tetanus-Diphtheria-Pertussis

- Tdap (one dose- Adolescent/Adult) Date Given:____/____/_____
- Td Booster: (Every 10 years after one dose of Tdap) Date Given:_____/____/_____

3. Measles-Mumps-Rubella Must fulfill one of the following:

- Two doses at least 28 days apart: Dose #1:____/____/_____ Dose #2:____/____/_____
- Health Practitioner-diagnosed measles, mumps, and/or rubella disease:

  Measles: Date:____/____/_____ _____
  Practitioner's Signature

  Mumps: Date:____/____/_____ _____
  Practitioner's Signature

  Rubella: Date:____/____/_____ _____
  Practitioner's Signature
- Serological Evidence of Immunity:

  Measles: Positive Immune Titer: Date:____/____/_____

  Mumps: Positive Immune Titer: Date:____/____/_____

  Rubella: Positive Immune Titer: Date:____/____/_____

4. Varicella (Chickenpox) Must fulfill one of the following:

- Two doses at least 28 days apart: Dose #1:____/____/_____ Dose #2:____/____/_____
- Health Practitioner-diagnosed Varicella Disease Date:_____/____/_____ _____
  Diagnosing Practitioner's Signature
- Serological Evidence of Immunity: Positive Immune Titer: Date:____/____/_____

5. Hepatitis B (3 dose series) *Dose #1 must be given prior to admission to the nursing major.

- Dose #1:* ____/____/_____ Positive Immune Titer: Date:_____/_____/_____
- Dose #2: ____/____/_____(at least one month after 1st dose)
- Dose #3:_____/____/_____(at least 2 months after 2nd dose AND at least 4 months after 1st dose)

6. Influenza

- One dose annually during influenza season: Date Given:____/____/_____

STUDENT:

_____ _____
Student Signature Date

_____ _____
Parent/Guardian Signature (if student is less than 18 years of age) Date

HEALTH CARE PROVIDER: (signature required as validation of correct information for immunizations and TB assessment). Note: Stamped signatures are not accepted.

Printed Name: _____

Address: _____

Phone: _____

Signature:_____Date: _____

Please Circle One: LPN RN PA-C NP MD DO

MEDICAL CONTRAINDICATION STATEMENT

The individual on this form has been diagnosed with a medical condition which precludes receiving the following vaccines:

VACCINE	MEDICAL CONTRAINDICATION*	DURATION OF CONTRAINDICATION

Note: Name, address, telephone number, and SIGNATURE of the physician are required to validate the medical exemption. STAMPED SIGNATURES ARE NOT ACCEPTED. Below signature is for Medical Contraindications only.

Health Care Provider's Name: _____
Address: _____
_____
Telephone Number: _____
Signature: _____ Date: _____

Medical Contraindications to vaccine(s) must be in accordance with the below recommendations of the Advisory Committee on Immunization Practices.

General Contraindication:

- Anaphylactic reaction to a vaccine contraindicates future doses of vaccine.
- Anaphylactic reaction to a vaccine substance contraindicates the use of vaccine containing that substance.

Contraindications to MMR or Varicella (VZV):

- Anaphylactic reaction to eggs or Neomycin (MMR); gelatin or Neomycin (VZV)
- Pregnancy
- Known altered immunodeficiency (hematologic & solid tumors, congenital immunodeficiency, or long term immunosuppressive therapy)

Contraindications to TB (Mantoux) skin test:

- Recent live virus vaccines (MMR or Varicella). Apply TB Mantoux (PPD) skin test 4-6 weeks after administration of live virus vaccine if not administered at the same visit.
- Documentation of Positive Mantoux (PPD)

I have declined to receive the above vaccine(s) for the reason stated above. I acknowledge that the vaccination(s) are recommended by the CDC for all healthcare workers to prevent infection from and transmission of the disease(s) and its complications, including death, to patients, my coworkers, my family and my community. I also understand that, based on individual clinical site regulations, I may be unable to participate in a clinical assignment.

I have read the above and I choose to decline the vaccination(s) (initial)_____.

Name (print): _____

Signature: _____ Date: ____/____/_____

Approved 2/28/11, Department of Baccalaureate Nursing
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