Indiana State University
School of Nursing

Immunization Record

The nursing program immunization record MUST be completed and signed by an appropriate healthcare provider as well as the applicant and submitted with all School of Nursing program applications.

Submission of other immunization documentation is not sufficient for application.

Use the below list to ensure all requirements are properly documented. *We recommend taking these guidelines to your provider with the form.* For more detailed information, please review the full Student Health policy.

Tuberculosis Screening (page 1)

- An initial two-step skin test (this means two separate tests administered 1-3 weeks apart) or blood test (Quantiferon Tb-Gold or T.SPOT-TB) is required for application and must be included on the form.
- Applicants that have been tested every 364 days since the initial two-step skin test (or blood test) must include a current (within the last 364 days) test in the Annual One-Step section.
- Applicants that have not been tested within 364 days must complete the two-step skin test again (or a new blood test).
- An initial positive tuberculin skin test requires a Quantiferon Tb-Gold or T.SPOT-TB blood test.
- A positive Quantiferon Tb-Gold or T.SPOT-TB blood test requires a medical exam and chest x-ray.
- For individuals with latent TB, a current (within the last 364 days) negative chest x-ray and provider documentation of a treatment plan is required, followed by completion every 364 of the TB Assessment questionnaire.
- For individuals that have completed a TB medication protocol, a current (within the last 364 days) negative chest x-ray is required, followed by completion every 364 days of the TB Assessment questionnaire and possible chest x-ray and medical follow-up. Documentation of medication protocol, including treatment completion date, is required.
- For individuals who are known positive tuberculin skin-test screeners, a current (within the last 364 days) Quantiferon Tb-Gold or T.SPOT-TB blood test is required, followed by completion every 364 days of the TB Assessment questionnaire and possible chest x-ray and medical follow-up.

Tetanus-Diphtheria-Pertussis (page 1)

- An adolescent/adult dose of Tdap is required. This dose was not available before 2005, so a dose from a year prior is likely a pediatric version and not sufficient.
- The Tdap vaccine is good for 10 years. A Td booster is then required.
- Another Tdap may be received in place of a Td booster. If another Tdap is given instead of a Td booster, the new Tdap should be listed on the Tdap line of the form.

Measles-Mumps-Rubella (page 2)

The form must document:

- Two dose vaccine series (at least 28 days apart); OR
- Serological evidence of immunity (positive titers) for ALL three diseases; OR
- Date of practitioner diagnosis for ALL three diseases with practitioner's signature on each (stamped signatures are not accepted).

Varicella (page 2)

The form must document:

- Two dose vaccine series (at least 28 days apart); OR
- Serological evidence of immunity (positive titer); OR
- Date of practitioner diagnosis with diagnosing practitioner's signature (another provider cannot sign off on diagnosis date, and stamped signatures are not accepted).

Hepatitis B (page 2)

The form must document:

- Three dose vaccine series (see dose schedule on form); OR
- Serological evidence of immunity (positive titer).

*Only the first dose is required for application to the major.

Influenza (page 2)

- Vaccine date for current influenza season should be entered. Vaccine dates from past years should not be listed.

Required Signatures (page 2)

- Student/applicant must sign and date in the Student section page 2.
- Parent/guardian signature required for students under 18.
- Health Care Provider section must be completely filled out, including address, phone and provider type (circled).
- Stamped provider signatures are not sufficient.

Medical Contraindications (page 3)

- This page must be completed if any of the above requirements cannot be fulfilled due to medical conditions (temporary or permanent).
- Specific duration of contraindication must be included.
- Lifetime contraindication should be documented for applicants that are positive TB skin testers due to receipt of BCG vaccine (applicant must complete blood test to apply as detailed in TB screening section of this document).
- Stamped provider signatures are not accepted.
- Applicant must initial, print, sign and date.

Approved 2/28/11, Department of Baccalaureate Nursing
Approved, 3/1/11, Department of Baccalaureate Nursing Completion Updated 7/11/2014, 2/26/16
Approved, 3/1/2016, Department of Advanced Practice Nursing
Approved, 9/20/22, SON Student Affairs Committee 6/0/0
Acknowledged by SON Steering Committee 9/21/2022

Nursing Program – Immunization Record

(To be submitted with application to the program 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: ____/____/_____