

### STUDENT IMMUNIZATION RECORD

I understand that my immunization record and other documentation is required in order to attend clinical courses, that it may be required for a future clinical experience/employer and that the College of Nursing is not responsible for providing submitted documentation to me. I will keep a record of my immunizations.

Student signature \_\_\_\_\_ Student name \_\_\_\_\_ DOB \_\_\_\_\_

**HEALTH PROFESSIONAL: COMPLETE THIS SECTION**

Please  the appropriate box to signify that the requirement has been met. Provide additional documentation/explanation if appropriate.

**Documentation of additional vaccination will be required for negative serology results.**

Disease	HCW Requirements for Immunity
<b>MMR (Measles, Mumps, Rubella)</b>	<input type="checkbox"/> Measles Positive serology – Date _____ (lab results required) <input type="checkbox"/> Mumps Positive serology – Date _____ <input type="checkbox"/> Rubella Positive serology – Date _____ <b>OR</b> <input type="checkbox"/> 2 MMR vaccines - Dates 1. _____ 2. _____
<b>Hepatitis B</b>	<input type="checkbox"/> Positive serology – Date _____ (lab results required) <b>OR</b> <input type="checkbox"/> Three doses of Hepatitis B vaccine; the first 2 doses given at least one month apart, and 3 <sup>rd</sup> given at least 4 months after the 2 <sup>nd</sup> <b>Dates of Hepatitis B Vaccine:</b> 1. _____ 2. _____ 3. _____ <b>OR</b> <input type="checkbox"/> Two doses of HEPLISAV-B vaccine – 1 month apart: 1. _____ 2. _____
<b>Tetanus, Diphtheria, Pertussis</b>	<input type="checkbox"/> 1 dose of Tdap (Adacel) (NOTE: Neither Td nor DTaP meet this requirement). <b>Date of Tdap Vaccine:</b> 1. _____ <b>If Tdap is older than 10 years, also provide date of subsequent Td Vaccine:</b> _____
<b>Varicella (Chicken pox)</b>	<input type="checkbox"/> History of varicella (Chickenpox) or zoster (Shingles) Date or year: _____ <b>OR</b> <input type="checkbox"/> Positive serology – Date _____ (lab results required) <b>OR</b> <input type="checkbox"/> 2 doses of VZV vaccine, 4-8 weeks apart. Prior recipients of 1 dose of vaccine must receive a 2 <sup>nd</sup> vaccine dose. <b>Dates of Chicken pox Vaccine:</b> 1. _____ 2. _____

\_\_\_\_\_  
**Signature (physician/nurse practitioner verifying information)      Printed name      Date signed**

NAME/ADDRESS/PHONE OF HEALTH CARE PROVIDER

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
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**NOTE TO STUDENT: A copy of an electronic immunization record from your healthcare provider will satisfy this requirement if the document includes all necessary information.**