Student Immunization Record

to be completed by Healthcare provider

This form must be completed with the proper signatures then uploaded to Certified Background by the student

Last Name ______________________________ **First Name** ______________________ **MI** ________

Birth Date (Month/Day)Year) ______________________________ **Student ID #** ______________________

Required Immunization	Date Immunization Received or Titer	Date Immunization Received or Titer	Date Immunization Received or Titer	Date Immunization Received or Titer	Date Immunization Received or Titer	Date Immunization Received or Titer	Antibody Titer Results + = immune - = not immune (attach copy of results)
Diphtheria, Tetanus, Pertussis (DTP) Report 5 doses	Dose 1 Date	Dose 2 Date	Dose 3 Date	Dose 4 Date	Dose 5 Date	Td Booster (10 yrs after TDAP)	
Tetanus/Diphtheria/ Pertussis (TDAP) Must be July 2005 or later	Dose Date						
Polio Report 4 doses	Dose 1 Date	Dose 2 Date	Dose 3 Date	Dose 4 Date			+ / -
Hepatitis B or Hepatitis A/B Combo Report 3 doses **or** titer results First 2 doses required by midterm of semester 1	Dose 1 Date	Dose 2 Date	Dose 3 Date				+ / -
Varicella (Chicken Pox) Report 2 doses **or** titer results	Dose 1 Date	Dose 2 Date					+ / -
Measles (Rubeola) Report 2 doses after age 12 months **or** titer results	Dose 1 Date	Dose 2 Date					+ / -
Mumps Report 2 doses after age 12 months **or** titer results	Dose 1 Date	Dose 2 Date					+ / -
Rubella (German Measles) Report 2 doses after age 12 months **or** titer results	Dose 1 Date	Dose 2 Date					+ / -
Influenza Annual Requirement Due before November 1	Flu Season	Dose Date					
2 Step Tuberculin Skin Test Within past 6 months Annual Requirement	Date	Date Read Induration mm	Date	Date Read Induration mm			

For any POSITIVE TB skin test, provider must document steps taken (chest x-ray etc.) **or** if latent tuberculosis was previously diagnosed, verification that patient is symptom free or receiving treatment. Attach physician note.

Signature ______________________________ Date __________

Medical Exemptions: Provider must document medical conditions that preclude that administration of a required vaccine or test. Explain medical exemption:

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Signature ______________________________ Date __________

I certify that this information is true and accurate. I understand that it is my responsibility to be fully immunized so I can participate in nursing clinical.

Student Signature ______________________________ Date __________

To be completed by Health Care Provider: I have verified the above documented immunizations.

Clinic/Facility Name: ______________________________ Telephone: ______________

Address: ______________________________ Fax: ______________

Healthcare Provider's Signature ______________________________ Date __________

(Must be a MD, DO, RCN, PA, NP, RN, LPN or CMA)