Addendum B

TEXAS STATE UNIVERSITY – ST. DAVID’S SCHOOL OF NURSING
2016 Immunization and Tests Form

Student’s Name: ___________________  TXSTATE ID:  A0  Date of Birth: ________________

**MEASLES/MUMP**
If student has had 2 MMR vaccines at least 30 days apart – on or after their first birthday. Document these dates below under each immunization. Combined MMR vaccine is vaccine of choice if student is likely to be susceptible.

- **Measles – One of the following is required:**
  Two doses of the Measles vaccine on or after the student’s first birthday and at least 30 days apart.  
  Date #1 (mm/dd/year): ___________________
  Date #2 (mm/dd/year): ___________________
  OR
  Record of healthcare provider diagnosed Measles.  
  Date disease occurred (mm/dd/year): ________________
  OR
  Serologic test positive for Measles antibody.  
  Note: Must be the date of diagnosis or test collection – not when healthcare provider signed this Immunization and Test Form.  
  Date of test (mm/dd/year): ________________  Result: ________________

- **Mumps – One of the following is required:**
  Two Mumps vaccines on or after student’s first birthday and at least 30 days apart. 
  Date #1 (mm/dd/year): ________________  Date #2 (mm/dd/year): ________________
  OR
  Record of healthcare provider diagnosed Mumps.  
  Date disease occurred (mm/dd/year): ________________
  OR
  Serologic test positive for Mumps antibody.  
  Note: Must be the date of diagnosis or test collection – not when healthcare provider signed this Immunization and Test Form.  
  Date of test (mm/dd/year): ________________  Result: ________________

- **Rubella – One of the following is required:**
  Two Rubella vaccines on or after the student’s first birthday and at least 30 days apart. 
  Date #1 (mm/dd/year): ________________
  Date #2 (mm/dd/year): ________________
  OR
  Record of healthcare provider diagnosed Rubella. 
  Date disease occurred (mm/dd/year): ________________
  OR
  Serologic test positive for Rubella antibody.  
  Note: Must be the date of diagnosis or test collection – not when healthcare provider signed this Immunization and Test Form.  
  Date of test (mm/dd/year): ________________  Result: ________________
VARICELLA (CHICKEN POX) – One of the following is required:

Two Varicella vaccines administered 4 – 8 weeks apart.  
OR  
Record of healthcare provider diagnosed Varicella.  
OR  
Serologic test positive for Varicella antibody.  
Note: Must be the date of diagnosis or test collection – not when healthcare provider signed this Immunization and Test Form.

Date #1 (mm/dd/year): ___________  Date #2 (mm/dd/year): ___________

HEPATITIS B – One of the following is required:

Three doses of vaccine administered over a period of 4 – 6 months. Initial vaccine followed by 1 and 4 – 6 months vaccines respectfully.

Date #1 (mm/dd/year): ___________  Date #2 (mm/dd/year): ___________  Date #3 (mm/dd/year): ___________

OR  
Serologic test positive for Hepatitis B.  
Note: The first two administrations must be completed by July 18, 2016 deadline. It is the student’s responsibility to schedule the third administration. Upload documentation of this third administration onto your Certified Background account.

Date (mm/dd/year): ___________  Result: ___________

Documentation must include:

➢ Your name  
➢ Date of birth  
➢ Date injectable vaccine was administered  
➢ Dose  
➢ Injection site  
➢ Lot #  
➢ Manufacturer of vaccine  
➢ Date of expiration  
➢ Signature of vaccine administrator

TETANUS – One of the following is required:

TDAP – Unless Td is in the last two years.  
OR  
Diphtheria, Tetanus (Td) – One dose within the past ten years at the time of application.

Date (mm/dd/year): ___________

Note: It is the student’s responsibility to schedule either the Td or Tdap booster if it expires while in nursing school. Documentation is to be uploaded under an Immunization and Tests. Documentation must include:

➢ Your name  
➢ Date of birth  
➢ Date injectable vaccine was administered  
➢ Dose  
➢ Injection site  
➢ Lot #  
➢ Manufacturer of vaccine  
➢ Date of expiration  
➢ Signature of vaccine administrator
MENINGOCOCCAL VACCINE – Evidence of vaccination is required if student is 21 years or younger on the first day of the fall semester (Monday, August 29, 2016).

Also submit proof of this vaccination to Texas State University. Date (mm/dd/year): ________________

Note: For students who are 22 years and older: The Meningococcal vaccine is not required by the St. David’s School of Nursing but it is recommended. Rationale: During clinical rotations in hospitals and community centers you will be exposed to a wide variety of patients including those with meningitis.

TB SKIN TEST/ T-SPOT – One of the following is required: 2-Step TB Skin Test or blood assay (T-Spot blood test or QuantiFERon)

If you choose the 2-Step TB Skin Test: The first test with reading must be done on or after May 31, 2016. The second test with reading must be seven or more days from the first administration (with reading) and completed prior to the July 18, 2016 deadline.

1st administration date: ____________ Date of read (mm/dd/yy): ____________ Result: ____________

2nd administration date: ____________ Date of read (mm/dd/yy): ____________ Result: ____________

If a prior positive reactor to TST, must show documentation of negative blood assay within 90 days. If you are a Texas State student you may obtain this blood assay may be obtained at the Student Health Center in San Marcos and Round Rock. The blood assay is also available at the Williamson County Health Department at a reduced cost.

T-Spot blood test Administration date (mm/dd/yy): ____________ Result: ____________

OR QuantiFERon blood test Administration date (mm/dd/yy): ____________ Result: ____________

If prior positive blood assay, present a negative chest X-ray within past 2 years, be free of productive cough, night sweats or unexplained loss of weight. The TB Assessment (St. David’s School of Nursing Tuberculosis Symptom Screen Form) is to be completed by a healthcare provider. This document is posted on Certified Background.

Date of negative chest X-ray (mm/dd/yy): __________________________

Healthcare provider’s printed name: __________________________________________

Address: ______________________________________________________________

Signature of healthcare provider: ___________________________ Date: __________

__________________________________________________________
Signature validates all of the above information.

After your healthcare provider completes this 2016 Immunization and Test Form including his/her signature, please upload the completed document onto your Certified Background account.