Student's Name: ______________________________TXSTATE ID#: A0_________________ Date of Birth: __________________

Addendum A
Texas State University
College of Health Professions
Immunizations and Tests Form

Measles/Mumps/Rubella Vaccine - One of the following is required:	
A. Two doses of measles vaccine at least 28 days apart **OR**	Administration Date #1 __________ (mm/dd/yy) Administration Date #2 ______________ (mm/dd/yy)
B. Serologic test positive for measles antibody	Date________________________ (mm/dd/yy) Circle Results: Positive Negative
Varicella (Chicken Pox) - One of the following is required: **A.** Two doses of Varicella vaccine administered 4-8 weeks apart **OR**	Administration Date #1 __________ (mm/dd/yy) Administration Date #2 __________ (mm/dd/yy)
B. Serologic test positive for Varicella antibody	Date __________________________ (mm/dd/yy) Circle Results: Positive Negative

Tetanus (TDAP): Tdap protects against Tetanus, Diphtheria, and Pertussis. This vaccine is to be given every ten years. (Td is not acceptable)	Date ____ (mm/dd/yy)

Meningococcal Vaccine: Evidence of vaccination if student is 21 years or younger on the first day of the semester.	Date ____ (mm/dd/yy)

Flu Shot Evidence of vaccination.	Date ____(mm/dd/yy)

Student's Name: ___________________________TXSTATE ID#: A0_______________ Date of Birth: ________________

HEPATITIS B (HEP B) Surface Antibody (titer) - draw titer to document immunity. This should be drawn no sooner than 1-2 months after last Hep B dose received. And the titer must be drawn within 12 months of admission into the nursing program. *Titer results must be quantitative with reference ranges included in the results.*	Date titer drawn (mm/dd/yy): _____________ Circle Results: Positive Negative

A titer showing non-immunity (non-reactive, negative) will require 1-3 repeat doses of Hepatitis B and a repeat titer 1-2 months after the last doses of vaccine. You may retiter 28 days after the booster/challenge dose but must continue the series until immunity is documented. *The results must be quantitative with reference ranges included.*

*If additional doses are required to obtain immunity, document the doses and dates received below:

HEPATITIS B (HEP B) Series:

The 3-dose series of the vaccine administered over a period of at least 6 months (schedule of 0, 1, 6 months). Initial vaccine is followed by the second dose in 1 month and the third dose is 5 months after the second dose. Note: Third vaccine must be at least 6 months from initial vaccine.

Dose #1__Date #1 (mm/dd/yy): _____________________

Dose #2__Date #2 (mm/dd/yy): _____________________

Dose #3__Date #3 (mm/dd/yy): _____________________

OR

The 2-dose series (Heplisav-B) of the vaccine requires a minimum of 4 weeks between doses. The administration record must clearly identify the Heplisav-B series was given.

Heplisav-B Dose #1__(mm/dd/yy): _______________________

Heplisav-B Dose #2__(mm/dd/yy): _______________________

Student's Name: ________________________TXSTATE ID#: A0______________ Date of Birth: _______________

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Tuberculosis (TB) Testing:
2 Options

A. Two Step Tuberculin Skin Test

- First test with reading must be done prior to clinical assignment.
- Second administration (with reading) must be 7 or more days from the first administration.

OR

B. TB Blood test
*Use blood test if had prior positive blood test or if received BCG vaccine.

Attention: Healthcare provider

If a student tests positive for TB, include a synopsis of their treatment plan with this form. The following are suggested minimum requirements to be included in this plan:

- Blood test (T-Spot or QuantiFERon) if the two step skin test was positive
- Chest X-ray to be completed if positive blood test
- Current completed Tuberculosis Assessment and Symptoms Checklist. Attach the completed checklist (with student's name and DOB) as page 3 of this form.

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First Administration Date ________________________________

Date Read________________Circle Results: Positive Negative
____

Second Administration Date ______________________________
(minimum of 7 days from first administration)

Date Read________________Circle Results: Positive Negative
____

Circle type of test: T-Spot QuantiFERon

Date (mm/dd/yy):__________Circle Results: Positive Negative

Treatment plan for (Student's Name):_____________________________

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Physician or Approved Licensed Healthcare Provider Information:	
Printed Name	
Address	
Signature of Physician or Licensed Healthcare Provider*	Date

*** Validates all information above.**