### Measles/Mumps/Rubella Vaccine

- **A.** Two doses of measles vaccine at least 28 days apart
  - **OR**
  - Administration Date #1 ______ Administration Date #2 ______
    (mm/dd/yy)  (mm/dd/yy)

- **B.** Serologic test positive for measles antibody
  - Date__________ Circle Results: Positive  Negative
    (mm/dd/yy)

### Varicella (Chicken Pox)

- **A.** Two doses of Varicella vaccine administered 4-8 weeks apart
  - **OR**
  - Administration Date #1 ______ Administration Date #2 ______
    (mm/dd/yy)  (mm/dd/yy)

- **B.** Serologic test positive for Varicella antibody
  - Date__________ Circle Results: Positive  Negative
    (mm/dd/yy)

### 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)
**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.*

<table>
<thead>
<tr>
<th>Date titer drawn (mm/dd/yy):</th>
<th>____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circle Results:</td>
<td>Positive</td>
</tr>
<tr>
<td></td>
<td>Negative</td>
</tr>
</tbody>
</table>

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): _____________________
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.

<table>
<thead>
<tr>
<th>First Administration Date</th>
<th>Date Read</th>
<th>Circle Results:</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Second Administration Date (minimum of 7 days from first administration)</th>
<th>Date Read</th>
<th>Circle Results:</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
</table>

Circle type of test: T-Spot QuantiFERon

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

Treatment plan for (Student’s Name):

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

Physician or Approved Licensed Healthcare Provider Information:

<table>
<thead>
<tr>
<th>Printed Name</th>
<th>Address</th>
</tr>
</thead>
</table>

Signature of Physician or Licensed Healthcare Provider* Date

* Validates all information above.