School of Nursing – Texas State University Immunizations and Tests Form

Student Name:______________________________TXST ID: A0___________Date of Birth:__________

MEASLES/MUMPS/RUBELLA VACCINE – one of the following is required: Two doses of the MMR vaccine at least 28 days apart.

Date #1 (mm/dd/year):_________________________Date #2 (mm/dd/year):_______________________

OR

Serologic test positive for the Measles/Mumps/Rubella antibody.
Date of test (mm/dd/year):____________________________________ Circle Results: Positive Negative

---

VARICELLA (Chicken Pox) – one of the following is required:

Two Varicella vaccines administered at least 4 – 8 weeks apart.

Date #1 (mm/dd/year):_________________________Date #2 (mm/dd/year):_______________________

OR

Serologic test positive for Varicella
Date of test (mm/dd/year):__________________________________ Circle Results: Positive Negative

---

TETANUS: Tdap protects against Tetanus, Diphtheria, and Pertussis. This vaccine is to be given every ten years. Note: Td is NOT acceptable.

Administration Date (mm/dd/year):________________________

Note: It is the student's responsibility to schedule the Tdap vaccine if it expires while in nursing school. Upload documentation onto your Clinical Student account. Documentation must include:

- Your name
- Date of birth
- Name of vaccine
- Date 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 a student is 21 years old or younger on the first day of the fall semester. Also submit proof of this vaccine to Texas State University.

Date of vaccine (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 is recommended. Rationale: During clinical rotations in hospitals and community centers you will be exposed to a wide variety of patients including those who have Meningitis.

Student Name:__________________________ TXST 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/year): __________________________ 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/year): ___________________

Dose #2__Date #2 (mm/dd/year): ___________________

Dose #3__Date #3 (mm/dd/year): ___________________

<u>OR</u>

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__Date #1 (mm/dd/year): _______________________

Heplisav-B Dose #2__Date #2 (mm/dd/year): _______________________

It is the student's responsibility to schedule necessary vaccination titers or the necessary boosters/challenges. Upload documentation of this additional information into your Clinical Student account. Documentation must include:

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

Student Name: ________________________ TXST ID: _A0_____________ Date of Birth: ______________

TUBERCULOSIS (TB) TESTING: Must be completed between stated deadlines of July 1st, 2021 and July 31st, 2021.

2 Step TB Skin Test

First administration date(mm/dd/year): ______________________

Date of read (mm/dd/year):_____________________Circle Results: Positive Negative

Second administration date(mm/dd/year): ____________________

Date of read (mm/dd/year):_____________________Circle Results: Positive Negative

OR

TB Blood Test (circle test): T-Spot QuantiFERon

Date of test (mm/dd/year):_______________________ Circle Results: Positive Negative

OR

Attention: Healthcare provider

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

- Blood test (T-Spot or QuantiFERon) if prior positive blood test
- Blood test (T-Spot or QuantiFERon) if prior BCG vaccination
- Chest X-ray within the past two years
- Current completed Tuberculosis Assessment and Symptoms Checklist. Attach the completed checklist (with student's name and DOB to this form).

Treatment plan for: ____
(Student's Name)

Healthcare provider's printed name: ____

Business/Agency (address/city/state/zip):

____

Signature of healthcare provider: ____ Date: ________________

Signature validates all information on this Immunization form.

Students: After your healthcare provider completes this Immunizations and Tests Form including his/her signature, upload the completed form and your completed Health Certificate onto your Clinical Student account.

Revised 4/2021