All Nursing Students Immunization Record

v.4.17.2020

NOT CONFIDENTIAL

Immunization records are not confidential as required by law.

Name: ____ Female ☐ Male ☐
Last First Middle

Student ID#: ______________________ Date of Birth: mm dd yyyy ☐ UNDERGRAD ☐ MSN/APN

TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER, GIVE MONTH, DAY & YEAR

If convenient, you may attach an official copy of your immunization records, which must include all previous and recent shots.

1. REQUIRED IMMUNIZATIONS (LABORATORY REPORT MUST BE SUBMITTED FOR ALL BLOOD TITERS)

MMR #1 ____________ #2 ____________ **AND** **MMR Titers**

NOTE: MEASLES HAS TO BE LIVE, AFTER 1ST BIRTHDAY

Measles #1 ____________ #2 ____________ Date ____________ Immune ☐ Non-immune ☐

Mumps #1 ____________ #2 ____________ Date ____________ Immune ☐ Non-immune ☐

Rubella #1 ____________ #2 ____________ Date ____________ Immune ☐ Non-immune ☐

Varicella (Chicken Pox) *Disease Date*: ____________ **AND** **Varicella Titers**

OR Vaccine #1 ____________ #2 ____________ Date ____________ Immune ☐ Non-immune ☐

Hepatitis B #1 ____________ **AND** **Hepatitis B Titers**

#2 ____________ #3 ____________

HepBsAg Date ____________ Positive ☐ Negative ☐

HepBcore IgM Ab Date ____________ Positive ☐ Negative ☐

HepBsAb Date ____________ Immune ☐ Non-immune ☐

Adult Tdap Date ____________________ (within 10 years)

Influenza Vaccine Date ________________ (due annually)
AVAILABLE EVERY FALL

MENINGOCOCCAL (MENINGITIS) INFORMATION IS AVAILABLE AT:
http://www.cdc.gov/meningitis
AND
https://www.nj.gov/health/cd/documents/topics/meningo/meningo_requirements_highered.pdf

By signing below I attest to have read and understood the information on the CDC and New Jersey Department of Health website. Further questions and/or concerns have been clarified by my HealthCare Provider listed below.

☐ I have**received* the Meningitis Quadrivalent Vaccine on: mm / dd / yyyy

**If your initial dose was administered before your 16th birthday, you will be required a booster dose.*

STUDENT SIGNATURE: ______________________________ **DATE:** ______________

2. TUBERCULOSIS TEST: NURSING STUDENTS REQUIRE *A TWO STEP PPD*. (*Step 2 must be 1-3 weeks after the first)

Mantoux/PPD Test

Step 1 Date Given __________ Date Read __________ Result: ☐ Negative **Positive ☐ Size______mm *(induration)*

***Step 2** Date Given __________ Date Read __________ Result: ☐ Negative **Positive ☐ Size______mm *(induration)*

OR

QuantiFERON-TB Gold or T-Spot Test

Date______________________ Result______________________ **(LAB REPORT MUST BE ATTACHED)**

****Those with *a history* of positive PPD/Mantoux your Physician must complete:** https://www.fdu.edu/wp-content/uploads/2019/11/3862.pdf

Your chest x-ray report must be attached to this form.

Signature of Medical Provider: ______________________ Date: ____________

Medical Provider: ______________________ Phone: ( ) ____________

Address: ____

License Number
OR
Official Stamp of
Medical Provider

Proof of Immunity is required prior to entrance to the University and Clinical sites

You will be placed on medical hold until the above requirements are met