FDU
Student Health Services
Metropolitan Campus

All Nursing Students Immunization Record

Rev.7 4.3.2020

NOT CONFIDENTIAL

Immunization records are not confidential as required by law.

Name: _____ Female ☐ Male ☐
Last *First* *Middle*

Student ID#: _____ Date of Birth: m m d d y y y y ☐ 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's/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