### Student Information - To be completed by Student (Please print)

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
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<tr>
<th>DATE OF BIRTH</th>
<th>ADDRESS</th>
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<tr>
<th>EMAIL ADDRESS</th>
<th>PHONE</th>
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| Start Date: __________ (Ex: Spring 2020) | Anticipated Completion Date: __________ |

### Immunizations and Screening Tests

Listed below are the requirements for attending the School of Nursing. Lab report or physician verification of results required for all immunizations and tests. (Note: Some clinical sites may have additional compliance requirements.)

#### Hepatitis B

All students must have a Positive Titer. Date of Positive Titer: ____/____/____

Has the student completed the 3-injection Hepatitis B vaccine series?

If YES, Date of Dose #1: ____/____/____ Date of Dose #2: ____/____/____ Date of Dose #3: ____/____/____

If NO, does the student have a positive hepatitis B surface Ab titer (anti-HBs > 10 mIU/mL)? YES _____ NO _____

If titer is negative or equivocal student will be prompted to receive 1 booster shot. Booster Date: ____/____/____

#### Varicella (Chicken pox)

Must be completed prior to enrollment.

One of the following is required: Positive Titer or 2-dose vaccine series.

*Please note: History of disease is no longer acceptable for compliance.*

Date of Positive Titer: ____/____/____ OR Date of Dose #1: ____/____/____ AND Date of Dose #2: ____/____/____

If any titer is negative or equivocal student will be prompted to receive 1 booster shot.

Booster Date: ____/____/____

#### Measles, Mumps, Rubella (MMR)

#### Measles:

Has the student been immunized for MEASLES or had the MEASLES? YES _____ NO _____

Please provide documentation of MEASLES vaccination. 2 doses must be documented for all students.

Date of DOSE #1: ____/____/____ Date of DOSE #2: ____/____/____

Or, please provide documentation of antibody titer to confirm immunity.

Date of Positive Titer: ____/____/____
MUMPS:
Has the student been immunized for MUMPS or had MUMPS? YES _____ NO _____
Please provide documentation of MUMPS vaccination. 2 doses must be documented for all students.
Date of DOSE #1: ____/____/____ Date of DOSE #2: ____/____/____
Or, please provide documentation of antibody titer to confirm immunity.
Date of Positive Titer: ____/____/____

RUBELLA:
Has the student been immunized for RUBELLA or had the RUBELLA? YES _____ NO _____
Please provide documentation of RUBELLA vaccination. 2 doses must be documented for all students.
Date of DOSE #1: ____/____/____ Date of DOSE #2: ____/____/____
Or, please provide documentation of antibody titer to confirm immunity.
Date of Positive Titer: ____/____/____

TETANUS, DIPHTHERIA, PERTUSSIS (Tdap)
An adult dose (booster – Tdap received at/after age of eleven) of Tdap is required and Td is given every 10 years after Tdap booster.
Date of Tdap: ____/____/____

TUBERCULOSIS
All students must be screened for Tuberculosis within 12 months of enrollment. For initial TB screening:
One of the following is required:

If student has NEVER received a BCG vaccine:
  • 1-step PPD or blood assay test
    Tuberculin Skin Test: Date placed: ____/____/____ Date read: ____/____/____ Result ____________
    If PPD (TST) test is positive a negative QuantiFERON or T-spot TB blood test is required.
  • QuantiFERON or T-spot TB blood test (lab report or physician verification of results required) \ Results of QuantiFERON Test: Positive _____ Negative _____
If QuantiFERON or T-spot TB blood test is positive, a clear chest x-ray (dated AFTER the positive QuanitFERON/T-Spot results) is required. Submit TB test results AND lab report or physician verification of results.

If student has a history of Positive QuantiFERON or T-spot TB blood test:
  1. Does the student have a history of BCG vaccine? YES ________ NO ________
  2. Has the student been treated for latent TB? YES ________ NO ________
     a. If yes, treatment type and duration _________________________________
  3. A negative chest x-ray is required (dated after the positive Quantiferon or T-spot TB blood test)
     a. Date of chest x-ray: ____/____/____ Please attach results. If older than 12 months, include symptom review.
        Chest x-ray was Normal _______ Chest x-ray was Abnormal _______
If student has received a BCG vaccine:

4. QuantiFERON or T-spot TB blood test (lab report or physician verification of results required)
   Results of Quanti-FERON Test:  Positive ____  Negative ____

   If QuantiFERON or T-spot TB blood test is positive, a clear chest x-ray (dated AFTER the positive QuantiFERON/T-Spot results) is required. Submit TB test results AND lab report or physician verification of results.

If student has a history of Positive QuantiFERON or T-spot TB blood test:

1. Does the student have a h/o BCG vaccine? YES ____  NO ____
2. Has the student been treated for latent TB? YES ____  NO ____
   a. If yes, treatment type and duration ___________________________________________________________
3. A negative chest x-ray is required, dated after the positive QuantiFERON or T-spot TB blood test.
   Date of chest x-ray: ____/____/____
   b. Please attach results. If older than 12 months, symptom review is required.

   Chest x-ray was Normal ______  Chest x-ray was Abnormal _____

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**INFLUENZA – SPRING START ONLY**

For Students beginning their program in the SPRING semester only:

In concurrence with the Center for Disease Control’s recommendation, the nasal spray vaccine (Flu Mist) is not an acceptable flu vaccine and does not satisfy the flu vaccine compliance requirement.

Date of flu vaccine if received during this visit: ____/____/____

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**HEALTH CARE PROFESSIONAL INFORMATION AND SIGNATURE**

To be completed by licensed Health Care Professional.

I have reviewed all of the information on this form and certify that the information is complete and accurate.

Name: ________________________________________________________________
Address: __________________________________________________________________________
Telephone Number (with area code): ________________________________________________
Signature: _________________________________________________________________________
Date: ____/____/____

Copies of acceptable documentation should be attached to this form so the student can upload these documents into his/her CastleBranch account. Documentation includes copy of Lab Titer Report for Measles, Mumps, and Rubella, Personal immunization records (written in English), etc.