University of Incarnate Word School of Nursing and Health Professions
Immunization Requirements

This form documents completion of immunizations required prior to the first day of classes at the University of the Incarnate Word School of Nursing. Any medical contraindication must be documented by a physician. Should a clinical agency require additional immunizations, those will be the responsibility of the student. Note that Texas law requires students under the age of 22 to show proof of immunization against bacterial meningitis in the past five years.

NAME:	ID or SS#:

This section must be completed and verified by health care provider(s).

HEPATITIS B Series or
Hepatitis A&B Vaccine series

Completion of the Hepatitis B vaccine series (3 doses) or Hepatitis A&B vaccine series is required. Laboratory evidence will be accepted in lieu of vaccine documentation.

Name of Vaccine: Date of vaccine:

1.____
2.____
3.____
4.____

Above record verified by:

Name Date

TUBERCULOSIS

A skin test for tuberculosis is required within the previous 6 months unless medically contraindicated. A record of medical evaluation and recommended treatment/follow-up is required if history of positive results...

Test Date __________________ Results:____________

Or Medical Evaluation and Follow-up: Date__________ (Attach copy):

Above record verified by:

Name Date

VARICELLA (Chicken Pox)

Documentation of two doses of the Varicella vaccine or Laboratory report of positive immune serum antibody titer is required.

Date of 1st dose:________________________________
Date of 2nd dose:________________________________
OR
Date & result of Varicella titer:_____________________

Above record verified by:

Name Date

MMR (Measles, Mumps and Rubella) Documentation of two doses of the MMR vaccine or Laboratory report of positive immune serum antibody titer is required.

Date of 1st dose:________________________________
Date of 2nd dose:________________________________
OR
Date & result of titer(s): __________________________

Above record verified by:

Name Date

DIPTHERIA-TETANUS-ACELLULAR PERTUSSIS (TdaP)

Documentation of one dose following completion of Td primary series is required.

Date of dose:_____________________________

Above record verified by:

Name Date

SEASONAL INFLUENZA VACCINE

Documentation of one dose of the annual fall/winter vaccine for the current year is required at time of admission and will be required annually.

Date of dose:_____________________________

Above record verified by:

Name Date

Documents were verified by the following health care provider(s):

Name:____
Contact phone #:__________________________________
Name:____
Contact phone #:__________________________________
Name:____
Contact phone #:__________________________________