Immunization Record Form

Master *of* Science in Nursing

ANDERSON UNIVERSITY
School *of* Nursing

Please type or print all information.

Name _____
LAST FIRST MIDDLE

Date of birth _____

The following information must be completed by a healthcare provider

1. Rubella (German Measles)
Must have proof of one dose of vaccine OR a positive titer.

Immunization date:_____
Titer results:_____ Date:_____

2. Rubeola (Measles)
All persons born on or after 1/1/57 must show proof of 2 measles vaccination OR a positive titer OR documentation of disease by a physician.

Immunization date #1:_____
Immunization date #2:_____
Titer results:_____ Date:_____

3. Mumps
Immunization OR titer OR history of disease.

Immunization date:_____
Titer results:_____ Date:_____

4. Tetanus and Diphtheria
Primary series in childhood.

Immunization date #1:_____
Immunization date #2:_____
Immunization date #3:_____
Immunization date #4:_____

5. Tetanus
Booster within past 10 years required

Date:_____

6. Polio — Primary series in childhood
- If you were vaccinated for polio but are unable to provide documentation, you are required to provide documentation of one polio injection (IPV).
- If you were never vaccinated for polio, you are required to provide documentation of completion of a series of 3 polio injections over the period of 6 months.

Immunization date #1:_____
Immunization date #2:_____
Immunization date #3:_____

IPV:_____ *(if indicated)*

7. Chicken Pox
Must have had the disease OR positive Varicella antibody OR have had 2 doses of Varicella vaccine.

History of disease (circle one): YES NO
Vaccine #1:_____
Vaccine #2:_____
Titer results:_____ Date:_____

Continued on back.

8. TB screening (Mantoux)
Must be updated annually
*** If there is a past history of a positive PPD, a chest x-ray is required.*

Titer results:_____ Date:_____

Results of chest x-ray:_____
(if indicated)

9. Hepatitis B Vaccine

Three doses OR positive antibody required.

Signed waiver must be on file until series is completed.

Dose #1:_____

Dose #2:_____

Dose #3:_____

FOR OFFICE USE ONLY

In process:_____

Waiver on file:_____

HbsAG

Results:_____ Date:_____

Health-care provider's signature

Address

Phone number