Salisbury University Department of Nursing
Immunization Record

Items A-E MUST be completed and signed by a health care provider.

A. **Tdap** - one time dose of Tdap given after age 10 ..... Date: ____/____/____

B. **Td** – Td booster within the past 10 years if Tdap was given more than 10 years ago ..... Date**:** ____/____/____

C. **MMR (Measles, Mumps, Rubella) – 2 doses are required. If MMR was not given please skip to C1, 2, & 3.**

Date of 1st Dose (Given on or after 1st birthday) ..... Date: ____/____/____

Date of 2nd Dose ..... Date: ____/____/____

□ Born before January 1, 1957 considered immune

□ Titer □ Immune. ..... Date: ____/____/____

□ Immunized with live measles vaccine – 2 doses are required on or after 1st birthday

Date of 1st Dose ..... Date: ____/____/____

Date of 2nd Dose (at least 4 weeks after 1st dose) ..... Date: ____/____/____

2. Rubella (If given instead of MMR).

□ Titer □ Immune ..... Date: ____/____/____

□ Immunized with vaccine at age 1 or older ..... Date: ____/____/____

3. Mumps (If given instead of MMR)

□ Titer □ Immune ..... Date: ____/____/____

□ Immunized with vaccine at age 1 or older ..... Date: ____/____/____

D. Varicella (Chickenpox)

□ Had disease (Physician documentation attached) ..... Date: ____/____/____

□ Titer □ Immune ..... Date: ____/____/____

□ Immunized with vaccine – 2 doses are required – 4 weeks apart

Date of 1st Dose ..... Date: ____/____/____

Date of 2nd Dose ..... Date: ____/____/____

E. Hepatitis B

Dates received: First Dose: ____/____/____ Second Dose: ____/____/____ Third Dose: ____/____/____

or □ Titer □ Immune □ Non-Immune Date:____/____/____

F. Tuberculosis

You must provide proof of two tuberculosis skin tests (TST) at least one week apart, done within the last 12 months. If you have a positive result, you must attach a copy of a Chest X-ray report. Please also include dates of prophylaxis **t**herapy, if completed.

Note: Students who are currently practicing as RNs must submit one negative TST completed in the last months or if positive copy of Chest x-ray and/or evidence of treatment if indicated

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TST 1 Placement Date ____/____/____ Read Date ____/____/____ Result (mm of induration) Readers Initials

TST 2 Placement Date ____/____/____ Read Date ____/____/____ Result (mm of induration) Readers Initials

HEALTHCARE PROVIDER SIGNATURE: _____ DATE: _____

ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

STATEMENT BY STUDENT: I have personally supplied all the above information and attest that it is true and complete to the best of my knowledge.

STUDENTS NAME (Please Print):_____

Last First Middle Student ID

Student Signature: _____ Date: _____