NURSING
TEXAS A&M HEALTH SCIENCE CENTER

Immunization Record

Please print or type in the requested information. Submit this form to the College of Nursing by the appropriate deadline. Keep a copy for your records.

Last Name ______________________ First Name ______________________ Middle Initial ________

Birthdate or UIN ______________________

Nursing Program: ☐ Trad BSN ☐ Second Degree BSN ☐ Select BSN ☐ RN to BSN/MSN ☐ MSN-Educ ☐ MSN-FNP

VACCINE	DATE EACH DOSE GIVEN				
	1ST	2ND	3RD	4TH	BOOSTER
Diphtheria, Tetanus, Pertussis (Td, Tdap, DTP) 1 dose with TD booster every 10 years					
Measles, Mumps, Rubella (MMR) 2 doses (at least 4 weeks apart) Or positive titer ______________(student may verify by initials)					
Varicella (Chickenpox) 2 doses (at least 4 weeks apart) If you have had the chickenpox disease, provide the year, if known:____________________ (vaccine not required)					
Influenza Required for all students (current students must receive the seasonal vaccine each year and provide proof to the Office of Student Affairs).					
Bacterial Meningitis (MCV4, MPSV4) 1 dose within the 5 year period immediately preceding first class day Exceptions apply based on age > 22.					
Hepatitis A (Hep A) 2 doses, (0, 6 - 18 months after first dose); 1st dose must be completed at least one month prior to the 1st class day.					
Hepatitis B (Hep B) 3 doses (0, 1 month after 1st dose, 4–6 months after 2nd dose); 1st dose must be completed at least one month prior to the 1st class day. Or positive titer ______________ (student may verify by initials) **Hep B Surface Antibody** **(Required for all students to verify immunity)** Draw titer to document immunity 1-2 months after 3rd dose. If vaccine received in past, draw immunity to test for antibodies at any time. Reactive _______ yes _______ no (student may verify by initials) Titer should be reactive showing immunity. If it is negative, follow CDC recommendation of repeating the 3 dose series unless your physician/NP recommends otherwise.					

For information on immunization recommendations from the Centers for Disease Control, go to: http://www.cdc.gov/vaccines/

TB Skin (Round Rock pre-licensure students must submit to the Two-step Skin Test or TB Blood Assay; all other students may complete the regular Skin Test); Test required annually. List most recent date and reading	Year 1 Test Date: _____________ Year 2 Test Date: _____________	Reading: Year 1: ☐ Positive ☐ Negative Year 2: ☐ Positive ☐ Negative
If reading is positive, chest x-ray is required subsequent to positive result. **Please provide copy of x-ray report or other medical documentation. Date of x-ray: _______________**		

I certify that the above immunization records are complete and accurate to the best of my knowledge.

STUDENT SIGNATURE ______________________ DATE ____________