Miles Community College
Nursing Department
Immunization Records (page 1 & 2) must be submitted to Verified Credentials

Name: Last _____First _____Middle_____ Date of birth___/___/____

Permanent Mailing Address:_____

Home Phone_____ Cell Phone:_____ Email_____

CPR CERTIFICATION

I have attached a copy of my current CPR Certification. Yes No (Circle one)
My CPR certification is current and valid until _____(date)

MILES COMMUNITY COLLEGE HEPATITIS B VACCINATION POLICY

Hepatitis B illness is a potentially fatal disease caused by a virus which can be transmitted through mucus membranes, sexually, perinatally and through non-intact skin. The highest concentration of the virus is in the blood: thus exposure to blood is the most dangerous and "needle sticks" constitute the highest occupational risk for health care workers. Because health care worker are at two to four times greater risk than the general public, The Center for Disease Control has recommended immunization for all health care workers in high risk areas.

Your clinical experience will be in a wide variety of health care settings. This may increase your risk for accidental exposure to Hepatitis B virus. It is therefore **strongly recommended** that you receive vaccination to protect you from this disease.

Vaccination requires three separate vaccines received over a period of six months. Complete immunity will not be established until the end of this time period. It is to your advantage, therefore, to initiate your vaccination early so that you will have complete immunity when you begin your major clinical experiences. **This form must be submitted with either Section A or Section B completed.**

SECTION A

I have initiated my Hepatitis B Vaccine, which will be completed by _____
(Date)

_____ _____
(Signature) (Date)

OR

I have completed my Hepatitis B Vaccine:

1st Dose:_____(Date) 2nd Dose:_____(Date) 3rd Dose_____(Date)

Reactive titer attached _____(Date)

_____ _____
(Signature) (Date)

SECTION B

I understand the risks, and I choose NOT to protect myself with hepatitis B vaccination at this time.

_____ _____
(Signature) **(Date)**

TO BE COMPLETED BY HEALTH CARE PROVIDER

An official copy of Immunization/Vaccination can be used for validation as long as actual dates are listed. If no records of childhood immunizations are available, student may verbally validate.

REQUIRED IMMUNIZATION RECORD

Student's Name: _____

REQUIRED IMMUNIZATIONS	
VACCINATIONS	**DATE/S**
Measles, mumps, rubella (MMR) - or hx. of disease	
Tetanus, Diptheria, Pertussis (Td/Tdap). Substitute 1st time dose of Tdap for Td booster; then boost with Td every 10 years	
Varicella Titer or Hx. of Chicken Pox	
Hepatitis A Vaccines (recommended)	
Meningococcal Meningitis (recommended)	

PPD (Tuberculin Skin Test)

Date given:_____

Given by: _____

Date read: _____

Read by: _____

Results:

Negative: _____

Positive: *_____

+If PPD is positive, the physician's report of the chest x-ray is required.