

Nova Southeastern University Health Professions Division

Immunization Form

DO NOT MAIL records to your program office or admissions unless instructed to do so. Students must submit all immunization and physical examination forms to tracking the system specified by the program.

Name (Print) \_\_\_\_\_ Date of Birth (M) \_\_\_\_ (D) \_\_\_\_ (Y) \_\_\_\_

College Program \_\_\_\_\_ Phone # \_\_\_\_\_

TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER

REQUIRED: MEASLES, MUMPS AND RUBELLA VACCINE, or SEROLOGIC IMMUNITY to MEASLES and RUBELLA

MMR: Dose #1 (M) \_\_\_\_ (D) \_\_\_\_ (Y) \_\_\_\_ Dose #2 (M) \_\_\_\_ (D) \_\_\_\_ (Y) \_\_\_\_

OR

Measles immunity: (M) \_\_\_\_ (D) \_\_\_\_ (Y) \_\_\_\_ (lab result must be provided)

Mumps immunity: (M) \_\_\_\_ (D) \_\_\_\_ (Y) \_\_\_\_ (lab result must be provided)

Rubella immunity: (M) \_\_\_\_ (D) \_\_\_\_ (Y) \_\_\_\_ (lab result must be provided)

Immune: (Yes) \_\_\_\_ No \_\_\_\_ (lab result must be provided)

Either (a) 2 doses of MMR vaccine or, (b) 2 doses of Measles, 2 doses of Mumps and 1 dose of Rubella, or (c) proof of immunity to Measles, Mumps, and/or Rubella.

REQUIRED: VARICELLA VACCINE or SEROLOGIC IMMUNITY

(Note: history of Chicken Pox is not acceptable)

Varicella vaccine: Dose #1: (M) \_\_\_\_ (D) \_\_\_\_ (Y) \_\_\_\_ Dose #2: (M) \_\_\_\_ (D) \_\_\_\_ (Y) \_\_\_\_

OR

Varicella titer date: (M) \_\_\_\_ (D) \_\_\_\_ (Y) \_\_\_\_

Immune: (Yes) \_\_\_\_ (No) \_\_\_\_ (lab result must be provided)

If the titer is negative or equivocal, the student must provide evidence of 2 vaccines received in their lifetime.

REQUIRED: HEPATITIS B SERIES / HEPATITIS B TITER

Note: Your record will be considered INCOMPLETE until you have proof of serologic immunity as documented by a Hepatitis B Surface Antibody Titer. Please also note, you should only receive the Hepatitis B vaccine series one additional time if the first series did not result in immunity. After completion of the repeat three vaccines, you will need to have your titer redrawn after 60 days. If your lab results still do not show immunity you should consult your healthcare provider.

Hepatitis B Surface Antibody: (M) \_\_\_\_ (D) \_\_\_\_ (Y) \_\_\_\_ Immune: (Yes) \_\_\_\_ (No) \_\_\_\_ (lab result must be provided)

\*If your Hepatitis B Surface Antibody result shows immunity, you do not need to complete the three Hepatitis B vaccine series

\*If your Hepatitis B Surface Antibody result shows you are not immune, you must have the three Hepatitis B vaccines and follow-up with Hepatitis B Surface Antibody titer 60 days after completing all 3 vaccines.

If needed

Hepatitis B: Dose #1: (M) \_\_\_\_ (D) \_\_\_\_ (Y) \_\_\_\_ Dose #2: (M) \_\_\_\_ (D) \_\_\_\_ (Y) \_\_\_\_ Dose #3: (M) \_\_\_\_ (D) \_\_\_\_ (Y) \_\_\_\_

Follow-up titer after 60 days: (M) \_\_\_\_ (D) \_\_\_\_ (Y) \_\_\_\_ (if needed)

REQUIRED: TETANUS-DIPHTHERIA – Tdap

Tetanus/Diphtheria/Pertussis (Tdap)\*\* (M) \_\_\_\_ (D) \_\_\_\_ (Y) \_\_\_\_

\*\*Required. Due to the increased risk of pertussis in healthcare settings the Advisory Committee on Immunization Practices / CDC recommends "Healthcare personnel should receive a single dose of Tdap as soon as feasible if they have not previously received Tdap and regardless of the time since last Td dose." After receiving Tdap, routine booster shots against tetanus and diphtheria should follow existing guidelines every 10 years.

These immunization records will not expire

Valid for 10yrs

Mandatory Office or Healthcare Provider Stamp:

I certify that the information above is complete and accurate to the best of my knowledge:

Healthcare Provider Printed Name \_\_\_\_\_ Date MM/DD/YR \_\_\_\_\_

Healthcare Provider Signature \_\_\_\_\_ Office Phone # \_\_\_\_\_

Office Address \_\_\_\_\_

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Immunization Form Continued

PPD/Tuberculosis Screening

(Must be completed within 12 months prior to entering the program)

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College Program \_\_\_\_\_ Year entering program \_\_\_\_\_

TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER

\*\*Quantiferon Tuberculosis Testing can be done in lieu of PPD\*\*

A documented negative Quantiferon - TB Gold within 12 months prior to start of program will substitute for two-step PPD screening below.

Quantiferon - TB Gold \_\_\_\_\_ (results attached)

The renewal date will be set for one year from latest PPD or two years from latest chest X-ray

Please note that some clinical facilities do not accept the Quantiferon Gold test.

REQUIRED: 1st step PPD/Tuberculosis Screening

Step one:

PPD applied: (M) \_\_\_\_ (D) \_\_\_\_ (Y) \_\_\_\_ By: \_\_\_\_\_

PPD read: (M) \_\_\_\_ (D) \_\_\_\_ (Y) \_\_\_\_ By: \_\_\_\_\_

Results \_\_\_\_\_ (mm)

Positive \_\_\_\_ Negative \_\_\_\_ (if Step One is negative, proceed to Step Two, 7 days and no longer than 12 months from step one PPD.)

If positive, you must attach a chest x-ray report and will not be required to proceed to step two

Prophylactic treatment for positive PPD: Yes \_\_\_\_ No \_\_\_\_

Treated with: \_\_\_\_\_ x \_\_\_\_\_ (months)

Completed treatment date: (M) \_\_\_\_ (D) \_\_\_\_ (Y) \_\_\_\_

REQUIRED: 2nd step PPD/Tuberculosis screening (must be at least 7 days and no longer than 12 months from step one PPD)

Step two:

PPD applied: (M) \_\_\_\_ (M) \_\_\_\_ (Y) \_\_\_\_ By: \_\_\_\_\_

PPD read: (M) \_\_\_\_ (D) \_\_\_\_ (Y) \_\_\_\_ By: \_\_\_\_\_

Results \_\_\_\_\_ (mm)

Positive \_\_\_\_ Negative \_\_\_\_ (if Step One is negative, proceed to Step Two 1-3 weeks after step one.)

If positive, you must attach a chest x-ray report

Prophylactic treatment for positive PPD: Yes \_\_\_\_ No \_\_\_\_

Treated with: \_\_\_\_\_ x \_\_\_\_\_ (months)

Completed treatment date: (M) \_\_\_\_ (D) \_\_\_\_ (Y) \_\_\_\_

I certify that the information above is complete and accurate to the best of my knowledge:

Healthcare Provider Printed Name \_\_\_\_\_ Date MM/DD/YR \_\_\_\_\_

Healthcare Provider Signature \_\_\_\_\_ Office Phone # \_\_\_\_\_

Office Address \_\_\_\_\_

Mandatory Office or Healthcare Provider Stamp:

**Nova Southeastern University Health Professions Division**

**Certificate of Physical Examination**

Based on review of the patient's medical history, immunization records, and physical examination performed and on file in my office this date \_\_\_\_\_, it is my impression that

**Name of student** \_\_\_\_\_

**Social Security Number** \_\_\_\_\_

**College Program** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

has received the required immunizations and that he/she meets the physical requirements for attendance at Nova Southeastern University Health Professions Division.

I certify that the information herein is complete and accurate to be best of my knowledge.

Healthcare Provider Printed Name \_\_\_\_\_

Healthcare Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

MANDATORY Office or Healthcare Provider Stamp:

Office Phone Number \_\_\_\_\_

Office Address \_\_\_\_\_  
\_\_\_\_\_

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