# NSU Florida



**Name (Print)** _____ **DOB** (M)____(D)____(Y)____ **N# N**_____

**Program**_____**Phone Number**_____

**REQUIREMENT: MEASLES, MUMPS AND RUBELLA** – 2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and (1) dose of Rubella; or **QUANTITATIVE** serologic proof of immunity for Measles, Mumps and/or Rubella. Choose only one option and attach copy of lab results and/or immunization record.

**Option 1: MMR Vaccine**

Dose #1 (M)_____(D)_____ (Y) _____ Dose #2 (M)_____(D)_____ (Y) _____ (immunization record must be attached)

**OR**

**Option 2: Proof of Serologic Immunity (IgG, QUANTITATIVE results) – Serology only required if no documented proof of vaccine. If the titer is negative or equivocal, the student must provide evidence of 2 vaccines received in their lifetime.**

Measles Titer:(M)_____(D)_____(Y)_____ Immune: Yes_____No_____(lab result must be attached)

Mumps Titer: (M)_____(D)_____(Y)_____ Immune: Yes_____ No_____(lab result must be attached)

Rubella Titer: (M)_____(D)_____(Y)_____ Immune: Yes_____ No_____(lab result must be attached)

**REQUIREMENT: VARICELLA** - 2 doses of vaccine or positive **QUANTITATIVE** serology. Choose only one option and attach copy of lab results and/or immunization record.

**Option 1: Varicella Vaccine**

Dose #1 (M)_____(D)_____ (Y) _____ Dose #2 (M)_____(D)_____ (Y) _____ (immunization record must be attached)

**OR**

**Option 2: Proof of Serologic Immunity (IgG, QUANTITATIVE results) – Serology only required if no documented proof of vaccine. If the titer is negative or equivocal, the student must provide evidence of 2 vaccines received in their lifetime.**

Varicella Titer: (M)_____(D)_____(Y)_____ Immune: Yes_____No_____ (lab result must be attached)

**REQUIREMENT: HEPATITIS B** Vaccination --3 doses of Engergix-B, Recombivax or Twinrix or 2 doses of Heplisav-B followed by a **QUANTITATIVE** Hepatitis B Surface Antibody (titer) preferably drawn 4-8 weeks after 3rd dose. If your lab results do not show immunity, please consult your health care provider.

**Hepatitis B Surface Antibody Quantitative Titer (HBsAb/ anti-HBs IgG)**

Surface Antibody Titer: (M)_____(D)_____(Y)_____ Immune: Yes*_____No_____ (lab result must be attached)
*If immune no further vaccine for hep B is needed

**Original Series (if available) –** immunization record must be attached

Dose #1 (M)_____(D)_____ (Y) _____ Dose #2 (M)_____(D)_____ (Y) _____ Dose #3 (M)_____(D)_____ (Y) _____

**Repeat Series/Booster (IF NEEDED)**

Dose #1 (M)_____(D)_____ (Y) _____ Dose #2 (M)_____(D)_____ (Y) _____ Dose #3 (M)_____(D)_____ (Y) _____

Repeat Surface Antibody Titer: (M)_____(D)_____(Y)_____ Immune: Yes_____No**_____ (lab result must be attached)
**If your lab results still do not show immunity, contact your health care provider

**REQUIREMENT Tdap:** CDC recommends a single dose of Tdap for healthcare personnel who have never received Tdap regardless of the time since their most recent Td vaccination. After receiving 1 dose of Tdap, healthcare personnel should receive a dose of Td or Tdap every 10 years.

Tetanus/Diphtheria/Pertussis (Tdap) (M)_____(D)_____ (Y) _____ (immunization record must be attached)

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

**Healthcare Provider Printed Name** _____ **Date (M)_____(D)_____(Y)_____**

**Healthcare Provider Signature** _____ **Office Phone #** _____

**Office Address** _____
**Mandatory Office or Healthcare Provider Stamp:**



HEALTHCARE PROVIDER SIGNATURE AND STAMP IS REQUIRED ON ALL PAGES

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## Required: TUBERCULOSIS Screening PPD or Quantiferon Testing – Please attach supporting documentation

**Option 1: Quantiferon – A documented negative Quantiferon blood test dated within 12 months prior to the start of the program.**

(M)_____(D)_____(Y)_____ results: negative_____ positive*_____ (lab results must be attached)

*if positive please contact your health care provider

**OR**

**Option 2: PPD**

**Step 1:**

PPD applied: (M)_____(D)_____(Y)_____ By: _____

PPD read: (M)_____(D)_____(Y)_____ By: _____

Induration _____mm. Results: negative**_____ positive* _____

** If negative proceed to Step 2 if required.
*If positive please contact your health care provider, do not proceed to step 2.

**Step 2 (All incoming first year students need a 2 step PPD): Must be at least 7 days and no longer than 12 months from step one PPD.**

PPD applied: (M)_____(D)_____(Y)_____ By: _____

PPD read: (M)_____(D)_____(Y)_____ By: _____

Induration _____mm. Results: negative_____ positive* _____

*if positive please contact your health care provider

## Influenza Vaccine – 1 dose annually each fall – If required by program

Flu Vaccine: (M)_____(D)_____(Y)_____ (immunization record must be attached)

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

**Healthcare Provider Printed Name** _____ **Date (M)**_____**(D)**_____**(Y)**_____

**Healthcare Provider Signature** _____ **Office Phone #** _____

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## Requirement: Certificate of Physical Examination:

Based on review of the patient's medical history and physical examination performed and on file in my office on this date (M)_____(D)_____(Y)_____, it is my impression that this patient meets the physical requirements for attendance at Nova Southeastern University Health Professions Division.

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

**Healthcare Provider Printed Name** _____ **Date (M)**_____**(D)**_____**(Y)**_____

**Healthcare Provider Signature** _____ **Office Phone #** _____

**Office Address** _____

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