



Required Immunizations for Heritage University BSN Program Students 2018-2019

NAME: _____ HU STUDENT ID NUMBER: _____

Part II. DOCUMENTATION OF IMMUNIZATION REQUIREMENTS: To be completed ONLY by Health Care Provider (HCP) This section of the form should not be signed by student, parent, or spouse.

Instructions for HCPs: Documentation of immunity (AS DEFINED ON THIS FORM) is REQUIRED. Please initial each section; signature and credentials are requested at the end of the form. Lab reports must be submitted for titers. All sections must be completed for school acceptance.

1. CHILDHOOD IMMUNIZATIONS: A Primary childhood or adult series with DTaP/DTP/DT/Td is required. Students are expected to have received the childhood polio series. An adult IPV booster is an acceptable alternative.

The following question must be answered:

Were childhood immunizations completed? (i.e. DPT/Polio; ok to have completed in adulthood as explained above)

YES [] NO [] If YES, is this information by: VERBAL REPORT [] (records NOT reviewed) OR DOCUMENTED RECORDS [] (records reviewed) Provider's initials:

2. MEASLES (RUBEOLA): TWO doses of measles-containing vaccine (regardless of birthdate), or a positive IgG antibody titer. The doses must be on or after age 12 months, at least one month apart and a live virus vaccine after 01/01/68, given without Immune Globulin. MMR must have been received in 1971 or later.

#1 [] Mo [] Day [] Yr. Indicate type: [] Measles (single antigen vaccine) [] Measles/Rubella [] Measles/Mumps/Rubella (MMR not available in U.S. until 1971)

AND

#2 [] Mo [] Day [] Yr. Indicate type: [] Measles [] Measles/Rubella [] Measles/Mumps/Rubella

OR Positive Rubeola IgG Antibody Titer: [] Mo [] Day [] Yr. (LAB REPORT REQUIRED) Provider's initials:

If two MMRs were not documented in #2, please complete the following; otherwise skip to question #5 on the next page.

3. MUMPS: TWO doses of mumps-containing vaccine (regardless of birthdate) or a positive IgG antibody titer. The doses must have been received on or after the age of 12 months and at least one month apart. Mumps alone must have been live virus vaccine received after 01/01/80.

#1 [] Mo [] Day [] Yr. (must be after 1/1/1980) AND #2 [] Mo [] Day [] Yr. OR Positive Mumps IgG Ab titer: [] Mo [] Day [] Yr. (LAB REPORT REQUIRED) Provider's initials:

4. RUBELLA (GERMAN MEASLES): ONE dose of rubella (single antigen) vaccine on or after 12 months of age or a positive IgG antibody titer.

[] Mo [] Day [] Yr. - OR Positive Rubella IgG Ab titer: [] Mo [] Day [] Yr. (LAB REPORT REQUIRED) Provider's initials:



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- 5. VARICELLA: TWO doses of varicella-containing vaccine given on or after 12 months of age and at least one month apart or positive Varicella IgG antibody titer. History of disease will NOT be accepted. Only the vaccine or titer will meet requirements.

#1 / / AND #2 / / OR Positive Varicella IgG Ab titer: / / (LAB REPORT REQUIRED) Mo Day Yr. Mo Day Yr. (Varicella vaccine not available in U.S. until 3/1995)

Provider's initials:

- 6. TETANUS-DIPHTHERIA-PERTUSSIS: One dose of Tdap is required within the past 10 years. This vaccine became available in the U.S. in June 2005. Note: Td is a different vaccine, and does not substitute for Tdap. Titers are NOT accepted in lieu of Tdap vaccine.

Tetanus-Diphtheria-acellular Pertussis (Tdap) Date: / / Mo Day Yr (One dose needed within past 10 years)

Provider's initials:

- 7. HEPATITIS B: THREE DOCUMENTED DOSES of vaccine AND a positive QUANTITATIVE Hepatitis B surface antibody titer (HBsAb, or anti-HBs). The reference range is indicated on the lab report for quantitative results; a positive titer is equivalent to 10 mIU/mL or higher. Students who just started the series may note they are "in process" and forward documentation of further doses and titer results as soon as they become available. Those who have incomplete or no documentation of their series must complete a valid 3-dose series followed by the titer. It is recommended that students complete their 3-dose series prior to patient (or body fluid) contact in practicum/clinical settings.

Dose #1 / / Dose #2 / / Dose #3 / / Dose #4 / / (optional, see below) Mo Day Yr. Mo Day Yr. Mo Day Yr. Mo Day Yr.

Provider's initials:

Additional doses: If more than 2 years have elapsed since a dose was given, we recommend an extra dose to boost antibodies to a detectable level. Then, draw the quantitative HbsAb titer 4-6 weeks later. If this titer is negative, testing for the antigen (HBsAg), a test of "carrier" status or prior exposure, may be indicated. If the HBsAg is negative, continue completing a 2nd series. Then re-check the HbsAb titer 4-6 weeks later. See the following algorithm for further details: http://www.immunize.org/catg.d/p2108.pdf

AND (Required): Positive quantitative Hepatitis B surface antibody (anti-HBs) titer:

Date: / / Indicate Reference Range Used: [] Int'l Units OR [] Index Value Provider's initials: (LAB REPORT REQUIRED) Mo Day Yr.

HEPATITIS B NON-RESPONDERS are those with a negative HBsAb after 2 documented 3-dose series of vaccine. In addition to proof of series completion and negative titers, Non-responders must submit proof of a counseling visit with a health professional to discuss their status and implications, such as immunizations necessary at time of blood borne pathogen exposures and need for rigorous adherence to standard precautions.

HEPATITIS B DISEASE: Those who have had the disease must attach the following laboratory results: Hepatitis B surface antibody, Hepatitis B surface antigen, and Hepatitis B core antibody. Students who are carriers (positive HBsAg) must show proof of a personal counseling visit with a provider about their carrier status (including discussion of need for rigorous adherence to standard precautions).

- 8. INFLUENZA: Seasonal influenza vaccine is required between August and November each year. Waivers are given only for students who have valid medical contraindications. A waiver request form (available from Heritage University Nursing) must be submitted annually. NOTE: Egg allergy is no longer a contraindication for most. Egg-free vaccine is available.

2018-2019 Seasonal Influenza vaccine Date: / / Indicate type: [] inactivated/injected vaccine [] live/nasal [] recombinant Mo Day Yr.



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- 9. **TUBERCULOSIS TEST (PPD):** Initial Two-Step PPD is required within 6 months of starting the program. Subsequent TB testing will be required annually. If history of positive TB Test: documentation of TB result, chest x-ray results, and completion of treatment are required. Also, see Tuberculosis Screening Form for the Heritage University 2018-2019 BSN student.

Dose #1 _____ / _____ / _____ Dose #2 _____ / _____ / _____
 Mo. Day Yr. Mo. Day Yr.

HEALTH CARE PROVIDER INFORMATION

NOTE: This section must be completed by HCP (MD, DO, NP, PA, RN or other appropriate designee) for authentication. Not to be completed by student or relative.

I certify the accuracy of all immunizations and other information detailed on this 2-page form:

 HCP's Signature

 Date

HCP's name printed/stamp of facility: _____

Phone # _____