Required Immunizations for Heritage University BSN Program Students 2021-2022

Part I. STUDENT INFORMATION This section of the form to be completed by student.

Name: ____
Last First

DOB: ______/______/______ HU Student ID Number: ____________________ Semester Starting: ____________________
Mo Day Yr.

REQUIRED: Heritage University Department of Nursing follows the recommendations of the Centers for Disease Control and Prevention (CDC), which are listed on this form. It is the student's responsibility to meet any requirements of a practice site that may differ from those recommended by the CDC.
By signing below I acknowledge I have read and agree to comply with the immunization requirements.

✶SIGNATURE: ✶ ______________________________ **DATE:** ______ /______ /______
(required) Mo Day Yr.

Please attach copies, not original records—all documents used for administrative purposes will be destroyed. Always keep the original or a copy for your personal records. This form must be completed in its entirety and received prior to your deadline.

Return by PDF attachment to Teresa Munguia at *Munguia_T@heritage.edu*

PLEASE COMPLETE ALL PAGES OF THIS PAGE FORM

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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: **(LAB REPORT REQUIRED)** ________________ Mo Day Yr. **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: **(LAB REPORT REQUIRED)** ____ _____ _____ Mo Day Yr.

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: **(LAB REPORT REQUIRED)** ______/______/______ Mo Day Yr **Provider's initials:**

PLEASE COMPLETE ALL PAGES OF THIS PAGE FORM

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NAME: ______________________________ **HU STUDENT ID NUMBER:** ______________

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:_____/_____/_____
Mo Day Yr. Mo Day Yr. **(LAB REPORT REQUIRED)** 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:_____/_____/_____ **Provider's initials:**
(One dose needed within past 10 years) Mo Day Yr

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:**
Mo Day Yr.

(LAB REPORT REQUIRED)

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.

2021-2022 Seasonal Influenza vaccine Date: _____/_____/_____ Indicate type: ☐ inactivated/injected vaccine ☐ live/nasal ☐ recombinant
Mo Day Yr.

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 2021-2022 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 #________ ____________________