Ila Faye Miller School of Nursing & Health Professions

STUDENT IMMUNIZATION RECORD

NAME (print or type): _____ **Date of Birth:** _____

UIW ID#: _____ **Contact Phone #:** _____

Program entering: ☐ **Undergraduate** ☐ **Graduate**

HEPATITIS B ONLY *OR* HEPATITIS A&B COMBO VACCINE

D A T E: 1.)_____ 2.)_____ 3.)_____

AND

Hepatitis B Antibody Titer: Date:_____ Immune:_____ Not Immune:_____ Value:_____

TUBERCULOSIS (TB Screen/PPD)

Date Placed:_____ Date Read:_____ Results: _____mm _____Positive _____Negative

OR

QUANTIFERON TB GOLD *or* TSpot

Results: _____Positive _____Negative

If positive reading

CXR Results:_____ Date:_____

VARICELLA (Chickenpox)

1ST Immunization date:_____ 2nd Immunization date:_____

OR

Varicella Titer Date:_____ Immune:_____ Not Immune:_____ Value:_____

MEASLES (RUBEOLA), MUMPS, and RUBELLA

1st Immunization Date:_____ 2nd Immunization Date:_____

O R

Measles Titer Date:_____ Immune:_____ Not Immune:_____ Value:_____
Mumps Titer Date:_____ Immune:_____ Not Immune:_____ Value:_____
Rubella Titer Date:_____ Immune:_____ Not Immune:_____ Value:_____

Tdap (Tetanus, Diphtheria, & Pertussis)	**FLU** (During current flu season only)	**COVID VACCINE** (May be required by certain clinical agencies for practicum)
Booster Date:_____	Date:_____	Date:_____ Date:_____

By signing below, I certify that the information above is true and correct:

PROVIDER NAME (print):_____ Title (RN, APRN, PA, MD, or DO): _____

Signature:_____ Date:_____

Daytime Phone: ( )_____

For office use only

Reviewer signature:_____ Date:_____