Pikes Peak State College RN-BSN Nursing Program Immunization Record

Student Name _____
Last First Middle Phone Number

Permanent Address _____
Street Number/Name City State Zip Code

Date of Birth [ ][ ][ ] PPSC S# _____ Student Email: _____
Mo Day Yr

PART A: TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. You may also attach any official state, clinic or hospital records, for example your flu shot receipt.

I. TETANUS, DIPHTHERIA & PERTUSSIS (Tdap)-booster must be within the last ten years [ ][ ][ ]
Mo Day Yr

II. MMR (Measles, Mumps, Rubella)
Two doses required, at least one month apart… Dose #1 [ ][ ][ ] Dose #2 [ ][ ][ ]
Mo Day Yr Mo Day Yr

Students in postsecondary education institutions, international travelers, and household or close personal contact of immunocompromised persons with no evidence of immunity to measles, mumps or rubella: 1 dose MMR if previously received 1 dose MMR, or 2-dose series MMR at least 4 weeks apart if previously did not receive any MMR. **-CDC, 2019**

OR ALL 3 OF THE FOLLOWING CRITERIA ARE MET:

MEASLES (RUBEOLA)
Has report of positive immune **titer**. **Specify date**: [ ][ ][ ] Value of Titer: _____
Mo Day Yr

Or **two doses** of individual rubeola vaccine: Dose #1 [ ][ ][ ] Dose #2
Mo Day Yr

RUBELLA (GERMAN MEASLES)
Has report of positive immune **titer**. **Specify date**: [ ][ ][ ] Value of Titer: _____
Mo Day Yr

Or **two doses** of individual rubella vaccine: Dose #1 [ ][ ][ ] Dose #2 [ ][ ][ ]
Mo Day Yr Mo Day Yr

MUMPS
Has report of positive immune **titer**. **Specify date:** [ ][ ][ ] Value of Titer: _____
Mo Day Yr

Or **two doses** of individual mumps vaccine: Dose #1 [ ][ ][ ] Dose #2 [ ][ ][ ]
Mo Day Yr Mo Day Yr

Healthcare personnel born in 1957 or later with no evidence of immunity to measles, mumps or rubella: 2-dose series MMR at least 4 weeks apart for measles or mumps, or at least 1 dose MMR for rubella; if born before 1957, consider 2-dose series MMR at least 4 weeks apart for measles or mumps, or 1 dose MMR for rubella

PART B: Hepatitis B, Varicella, Tuberculosis Screening

III. HEPATITIS B:

Has report of positive immune **titer**. **Specify date:** ☐☐☐ Mo Day Yr Value of Titer: _____

Or **three doses** of individual hepatitis vaccine:

Dose #1 ☐☐☐ Mo Day Yr Dose # 2 ☐☐☐ Mo Day Yr Dose #3 ☐☐☐ Mo Day Yr

IV. VARICELLA: (chicken pox): Two doses one month apart recommended for adults with no history of disease:

Has report of positive immune **titer**. **Specify date**: ☐☐☐ Mo Day Yr Value of Titer: _____
(*History of disease cannot be accepted*)

Or **two doses** of individual varicella vaccine: Dose #1 ☐☐☐ Mo Day Yr Dose #2 ☐☐☐ Mo Day Yr

V. TUBERCULOSIS:

1. Does the student have signs or symptoms of active TB disease? ☐ YES ☐ NO

If NO, proceed to 2.

If YES, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

PLEASE USE THE SPACE BELOW TO DOCUMENT TUBERCULIN SKIN TESTING AND/OR CHEST RADIOGRAPHY (Based on assessment criteria outlined above)

2. A. Tuberculin Skin Test/PPD:

Date given: ☐☐☐ Mo Day Yr Date read: ☐☐☐ Mo Day Yr Results: _____MM
(Record actual MM of indurations, transverse diameter; if no in duration, write "0")

Interpretation (based on MM of indurations as well as risk factors)

☐ Positive ☐ Negative

B. Chest X-Ray: (required if tuberculin skin test is positive or if PPD has not been placed but patient is at risk of disease; must have been performed.

Result: ☐ Normal ☐ Abnormal Date of chest x-ray: _____

INH Initiated ☐ ☐ Date_____X_____months

C. Quantiferon: Date of Test: _____ ☐ Positive (≥ 0.35 IU/mL) ☐ Negative

History of positive PPD and/or negative Quantiferon results requires annual TB screening with a Healthcare Provider:

1. Have you been having a bad cough that last longer than 2 weeks? ☐ YES ☐ NO
2. Have you been having pain in the chest? ☐ YES ☐ NO
3. Have you been coughing up blood or sputum (phlegm from deep inside the lungs)? ☐ YES ☐ NO
4. Have you experienced weakness or fatigue? ☐ YES ☐ NO
5. Have you experienced chills, fevers, or sweating at night? ☐ YES ☐ NO
6. Have you experienced weight loss or a loss of appetite? ☐ YES ☐ NO

CONTINUE on to Part C for Influenza Vaccine (Required for all students)

PART C. Influenza

VI. INFLUENZA:

Date of last dose: ☐☐☐ Mo Day Yr Lot # _____ Location given: _____

PART D. COVID 19

VI. COVID: Brand of Vaccine_____

Dose #1: ☐☐☐ Mo Day Yr Lot # _____

Dose #2: ☐☐☐ Mo Day Yr Lot # _____

Booster?: ☐☐☐ Mo Day Yr Lot # _____

***Is general health adequate to allow participation in a nursing education program and to perform essential duties of an RN working in a hospital or clinic, including CPR, administration of IV medication, opening of obstructed airways, catheterization, safe patient transfer/lifting, and other motor skills?**

YES _____ NO _____

HEALTH CARE PROVIDER: (signature required as validation of correct information for immunizations and TB assessment)

Printed Name: _____

Signature: _____

Date: _____

Address: _____
Street Number/Name

_____
City State Zip Code

Phone: _____

I _____(student) give consent for PPSC Nursing Program to share the results of the immunizations and physical questionnaire with clinical agencies as requested

_____ _____
Student Signature Date