Pikes Peak Community 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 [ ][ ][ ] (Mo Day Yr) PPCC S# _____ Student Email: _____

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 [ ][ ][ ] (Mo Day Yr) Dose #2 [ ][ ][ ] (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**: [ ][ ][ ] (Mo Day Yr) Value of Titer: _____

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

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

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

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

Or **two doses** of individual mumps vaccine: Dose #1 [ ][ ][ ] (Mo Day Yr) Dose #2 [ ][ ][ ] (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 PPCC Nursing Program to share the results of the immunizations and physical questionnaire with clinical agencies as requested

_____ _____
Student Signature Date