To: All College of Nursing Students  
From: Office of Student Affairs - College of Nursing.

College of Nursing (CON)-DO NOT MAIL records to your program or admissions. CON students must submit all immunization and physical forms to Certified Profile. CON students should contact Certified Profile Student Services at 888-914-7279 or email studentservices@certifiedprofile.com for questions regarding uploading documents.

DEADLINE to submit immunization records:

- Student starting the Nursing Program in Fall/August – deadline is November 1st
- Student starting the Nursing Program in Winter/January – deadline is March 1st

Immunization Requirement Guide

The following immunizations are **MANDATORY** requirement for the Health Professions Division.

1. **MMR** – this requirement is only satisfied by submitting either  
   a. A Measles IgG and Rubella IgG titer showing immunity OR  
   b. Two MMR vaccinations must be documented.

2. **Varicella** – this requirement is only satisfied by submitting either  
   a. A Varicella titer showing immunity OR  
   b. Two Varicella vaccinations must be documented  

   **NOTE:** Having had Chicken Pox DOES NOT satisfy requirement

3. **Hepatitis B**  
   a. Three (3) vaccinations should be documented for Hepatitis B

4. **Hepatitis B Surface Antibody**  
   a. Serologic testing is **REQUIRED** for Hepatitis B Surface Antibody. This means you must have your blood drawn to show if you are immune to Hepatitis B vaccine. A copy of your lab result must be attached.  

   **NOTE:** If the lab result shows that the student is not immune, he or she would be **REQUIRED** to start the Hepatitis B vaccinations.  

   **OPTION:** If the student has never completed HEPATITIS B vaccines, he or she can complete Hepatitis B titer showing immunity which will satisfy the HEPATITIS B requirement.

5. **Tetanus-Diphtheria**  
   a. Affirmation of diphtheria/tetanus booster must be documented. This booster is only valid for 10 years

6. **Tuberculosis Screening**  
   a. There is a two step requirement for PPD/Tuberculosis Screening. If the 1st step is negative, you must have another PPD placed at least 7 days and no longer than 12 months of step one. If the 1st step is positive, a copy of chest x-ray must be attached. You will be required to get yearly PPD until completion of the program.

7. **Physical**  
   a. Submit document signed by physician showing that you had a basic physical within the last 12 months prior to entering the program.

Failure to Comply: The University is not required to provide alternate sites for clinical practicum or rotations should immunization be a requirement for placement. Therefore, failure to comply with this policy may result in a student's inability to satisfy the graduation requirements in their program.

2/28/2013
# Nova Southeastern University Health Professions Division

## Immunization Form

**College of Nursing**—DO NOT MAIL records to your program or admissions. CON students must submit all immunization and physical forms to Certified Profile. CHCS students should contact Student Services at 888-914-7279 or email studentservices@certifiedprofile.com for questions.

<table>
<thead>
<tr>
<th>Name (Print)</th>
<th>Date of Birth (M) (D) (Y)</th>
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<tbody>
<tr>
<td>College Program</td>
<td>Phone #</td>
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</tbody>
</table>

**TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER**

### REQUIRED: MEASLES, MUMPS AND RUBELLA VACCINE, or SEROLOGIC IMMUNITY to MEASLES and RUBELLA

- **MMR:**
  - dose #1: (M) (D) (Y)
  - dose #2: (M) (D) (Y)
- **Measles immunity:** (M) (D) (Y) (lab result must be provided)
- **Mumps immunity:** (M) (D) (Y) (lab result must be provided)
- **Rubella immunity:** (M) (D) (Y) (lab result must be provided)

**Immune:** (Yes) (No) (lab result must be provided)

If you choose to provide immunity results and you are not immune, you must have the MMR Vaccines completed.

### REQUIRED: VARICELLA VACCINE or SEROLOGIC IMMUNITY

(No note: history of Chicken Pox is not acceptable)

- **Varicella vaccine:**
  - dose #1: (M) (D) (Y)
  - dose #2: (M) (D) (Y)
- **Varicella titer date:** (M) (D) (Y)

**Immune:** (Yes) (No) (lab result must be provided)

If you choose to provide immunity results and you are not immune, you must have the Varicella Vaccines completed.

### REQUIRED: HEPATITIS B SERIES / HEPATITIS B TITER

**Note:** Your record will be considered INCOMPLETE until you have proof of serologic immunity as documented by a Hepatitis B Surface Antibody Titer. Please also note, you should only receive the Hepatitis B vaccine series one additional time if the first series did not result in immunity. After completion of the three vaccines, you will need to have your titer redrawn after 60 days. If your lab results still do not show immunity you should consult your healthcare provider.

- **Hepatitis B Surface Antibody:** (M) (D) (Y) (lab result must be provided)
  - Immune: (Yes) (No) (lab result must be provided)
  - *If your Hepatitis B Surface Antibody result shows immunity, you do not need to complete the 3 Hep B vaccine series*
  - *If your Hepatitis B Surface Antibody result shows you are not immune, you must have the 3 Hep B vaccines and follow-up with Hepatitis B Surface Antibody titer 60 days after completing all 3 vaccines.*

**If needed**

- **Hepatitis B:**
  - dose #1: (M) (D) (Y)
  - dose #2: (M) (D) (Y)
  - dose #3: (M) (D) (Y)

**Follow-up titer after 60 days:** (M) (D) (Y) (if needed)

### REQUIRED: TETANUS-DIPHTHERIA – Tdap or Td

- Tetanus/Diphtheria/Pertussis (Tdap)**
  - (M) (D) (Y)
- Tetanus/Diphtheria (Td)
  - (M) (D) (Y)

**Due to the increased risk of pertussis in healthcare settings the Advisory Committee on Immunization Practices recommends Tdap for healthcare personnel. Tdap is recommended if it has been more than two years since your last Td booster.**

<table>
<thead>
<tr>
<th>I certify that the information above is complete and accurate to the best of my knowledge:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Provider Printed Name</td>
</tr>
<tr>
<td>Healthcare Provider Signature</td>
</tr>
<tr>
<td>Office Address</td>
</tr>
</tbody>
</table>

Mandatory Office or Healthcare Provider Stamp:

2/28/2013
Immunization Form Continued
PPD/Tuberculosis Screening
(Must be completed within six months prior to entering the program)

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Name (Print) __________________________________________________________ Date of Birth (M)____ (D) ____ (Y) _____

College Program __________________________________________________ Year entering program __________

TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER

**Quantiferon Tuberculosis Testing can be done in lieu of PPD**

A documented negative Quantiferon - TB Gold blood within 12 months prior to start of program will substitute for two step PPD screening below. Quantiferon - TB Gold Negative ___________________ (results attached)

REQUIRED: 1st step PPD/Tuberculosis Screening

Step one:

PPD applied: (M)____ (D) ____ (Y) _____ By: __________________________

PPD read: (M)____ (D) ____ (Y) _____ By: __________________________

Results _______________________ (mm)

- Positive_____ - Negative_____ (if step 1 is negative, proceed to step two).

If positive, you must attach a chest x-ray report and will not be required to proceed to step two

Prophylactic treatment for positive PPD: • Yes_____ • No _____

Treated with: _____________ x _________ (mths)

Completed treatment date: (M)____ (D) ____ (Y) ____

REQUIRED: 2nd step PPD/Tuberculosis screening (must be at least 7 days and no longer than 12 months from step one PPD)

Step two:

PPD applied: (M) ____ (M) ___ (Y) ___ By: __________________________

PPD read: (M) ____ (D) ___ (Y) ___ By: __________________________

Results _______________________ (mm)

- Positive_____ - Negative_____ (if step 1 is negative, proceed to step two 1-3 weeks after step one.)

If positive, you must attach a chest x-ray report

Prophylactic treatment for positive PPD: • Yes_____ • No _____

Treated with: _________________ x _________ (mths)

Completed treatment date: (M)____ (D) ____ (Y) ____

I certify that the information above is complete and accurate to the best of my knowledge:

Healthcare Provider Printed Name _______________________________ Date MM/DD/YR __________________

Healthcare Provider Signature _______________________________ Office Phone # __________________

Office Address __________________________________________________

Mandatory Office or Healthcare Provider Stamp:
Nova Southeastern University Health Professions Division

Certificate of Physical Examination

Based on review of the patient’s medical history, immunization records, and physical examination performed and on file in my office this date ______________________, it is my impression that

Name of student __________________________
Social Security Number _______________________ 
College Program ______________________________
Date of Birth ________________________________

has received the required immunizations and that he/she meets the physical requirements for attendance at Nova Southeastern University Health Professions Division.

I certify that the information herein is complete and accurate to be best of my knowledge.

Healthcare Provider Printed Name ____________________________
Date ______________________
Healthcare Provider Signature ________________________________

MANDATORY Office or Healthcare Provider Stamp:

Office Phone Number _________________________________________
Office Address _____________________________________________

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