Nova Southeastern University Health Professions Division

Immunization Form

DO NOT MAIL records to your program office or admissions unless instructed to do so. Students must submit all immunization and physical examination forms to tracking the system specified by the program.

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

College Program ____Phone # _________________________

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) _____

or

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)

Either (a) 2 doses of MMR vaccine or, (b) 2 doses of Measles, 2 doses of Mumps and 1 dose of Rubella, or (c) proof of immunity to Measles, Mumps, and/or Rubella.

REQUIRED: VARICELLA VACCINE or SEROLOGIC IMMUNITY
(Note: history of Chicken Pox is not acceptable)

Varicella vaccine: Dose #1: (M) ______ (D) ______ (Y) ______ Dose #2: (M) ______ (D) ______ (Y) ______

or

Varicella titer date: (M) ____ (D) ____ (Y) _____

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

If the titer is negative or equivocal, the student must provide evidence of 2 vaccines received in their lifetime.

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 repeat 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) _____ Immune: (Yes)_____ (No) _____ **(lab result must be provided)**
*If your Hepatitis B Surface Antibody result shows immunity, you do not need to complete the three Hepatitis B vaccine series
*If your Hepatitis B Surface Antibody result shows you are not immune, you must have the three Hepatitis 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)

These immunization records will not expire

REQUIRED: TETANUS-DIPHTHERIA – Tdap

Tetanus/Diphtheria/Pertussis (Tdap)** (M)____ (D) ____ (Y) ____
**Required. Due to the increased risk of pertussis in healthcare settings the Advisory Committee on Immunization Practices / CDC recommends "Healthcare personnel should receive a single dose of Tdap as soon as feasible if they have not previously received Tdap and regardless of the time since last Td dose." After receiving Tdap, routine booster shots against tetanus and diphtheria should follow existing guidelines every 10 years.

Valid for 10yrs

Mandatory Office or Healthcare Provider Stamp:

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 ____

Nova Southeastern University Health Professions Division

Immunization Form Continued

PPD/Tuberculosis Screening

(Must be completed within 12 months prior to entering the program)

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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 within 12 months prior to start of program will substitute for two-step PPD screening below.

Quantiferon - TB Gold ________________ (results attached)

The renewal date will be set for one year from latest PPD or two years from latest chest X-ray

Please note that some clinical facilities do not accept the Quantiferon Gold test.

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 One is negative, proceed to Step Two, 7 days and no longer than 12 months from step one PPD.)

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 _________ (months)

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 One 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 _________ (months)

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______________________________

Healthcare Provider Signature__________________________________ Date________________________

MANDATORY Office or Healthcare Provider Stamp:

Office Phone Number____

Office Address ____

____

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