ANGELO STATE UNIVERSITY NURSING PROGRAM
FACUTLY IMMUNIZATION RECORD

Name:_____ CID:_____

Current Mailing Address:_____

City: _____ State:_____ Zip:_____

Daytime Phone:_____ Date of Birth:_____

Program: (Please Check One) ☐ **Generic BSN** ☐ **MSN**

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IMMUNIZATION HISTORY

Must be completed by a physician or health care facility official AND signed at the bottom of this form.
Immunization records **MUST** accompany this form.
DO NOT SUBMIT BLANK FORM WITH RECORDS ATTACHED

Hepatitis B

3 doses of vaccine **AND** a positive titer (quantitative HBsAB >10mIU/ml) drawn 1-2 months after completion of the series

Vaccine #1_____Date (0mo)
Vaccine #2_____Date (1mo)
Vaccine #3_____Date (6mo)
Date of Titer: _____Results: _____ (1-2 months after last dose)

Negative titer after 3 dose series - repeat the 3 dose series booster **AND** titer

Booster vaccines

Vaccine #1_____Date (0mo)
Vaccine #2_____Date (1mo)
Vaccine #3_____Date (6mo)
Date of Titer: _____Results _____(1-2 months after last dose)

Negative titer after 1 dose booster - complete the remaining 2 vaccines in the series then a titer

Date of Titer: _____Results _____(1-2 months after last dose)

Negative titer after 2nd 3 dose series - provide one of the following:

Documentation of counseling provided from a medical provider for non-responder status **OR**
Documentation from a healthcare provider of other immunity to Hepatitis B.
Date of required documentation: _____

*Missing documentation: *Even if you have a positive titer*, complete the doses you are missing documentation on, or the whole series if needed, then complete the titer 1-2 months after the last vaccine.

**Completed only part of the series: *Even if you have a positive titer*, complete the vaccines you are missing in the series then complete the titer 1-2 months after the last vaccine.

***Completed the series, have documentation, but never had a titer drawn:

Complete a titer. If negative, obtain a one dose booster of vaccine, REPEAT titer.
2nd Negative titer -complete the final 2 doses of the series, REPEAT titer.
3rd Negative titer - see Negative titer after 2nd 3 dose series above.

COVID 19 Vaccine and Booster

Date of Shot #1:_____ Date of Shot #2:_____

Date of Booster:_____ _____ _____

Tetanus-Diphtheria-Pertussis (Tdap) and Tetanus and Diphtheria (Td)

Date of Tdap Vaccine (within the past 10 years):_____
Date of Td Vaccine (required 10 years after Tdap and every 10 years thereafter):_____

Name: _____ CID:_____

MMR (Measles, Mumps, Rubella):

2 doses of MMR vaccine on or after the 1st birthday separated by 28 days or more – no titers required

Date of MMR Vaccine #1_____

Date of MMR Vaccine #2_____

OR

2 doses of Measles (separated by 28 days or more), 2 doses of Mumps (separated by 28 days or more) and 1 dose of Rubella, (all after the 1st birthday) **OR** serologic proof of immunity for Measles, Mumps and/or Rubella

Date of Measles Vaccine #1_____ **OR** Date of Titer: _____ Results _____

Date of Measles Vaccine #2_____

Date of Mumps Vaccine #1_____ **OR** Date of Titer: _____ Results _____

Date of Mumps Vaccine #2_____

Date of Rubella Vaccine #1 _____ **OR** Date of Titer: _____ Results _____

Varicella (Chicken Pox)

2 doses of varicella vaccine given at least 28 days apart **OR** IgG titer

Date of Varicella Vaccine #1_____ **OR** Date of IgG (titer): _____Results _____

Date of Varicella Vaccine #2_____

Influenza

1 dose annually at the beginning of flu season (September/October)

Date of Flu vaccine:_____ Date of Flu vaccine_____ Date of flu vaccine_____

Tuberculosis Screening

2 negative TB skins tests (TST) then **annual** TST **OR** negative blood test (IRGA) then **annual** IGRA. ****History of positive TST or IGRA*

Negative TST within the last year

Date of TST #1 _____ (within the last year) Results: _____

Date of TST #2 _____ (current test) Results: _____

Never had a TST or TST > than 1 year ago

2 Step Skin Test

Date of Skin Test #1 _____(initial test) Results: _____

Date of Skin Test #2_____ (7-21 days from test #1) Results: _____

OR

TB Blood test (IGRA) within the last year

Date of IGRA _____ Results: _____

OR

****Positive TST or positive IRGA*?

1. **Provide documentation** of initial evaluation by a healthcare provider including: any treatment completed and negative chest x-ray. Date treatment Completed _____ Results of CXR:_____
2. Current TB screening questionnaire by healthcare provider (within the past year). Date: _____

Annual TB questionnaire screening by a healthcare provider is required.

FOR INTERNAL USE ONLY
Date of annual TST _____ Results _____
Date of annual TST _____ Results _____
Date of annual TST _____ Results _____
Date of annual IRGA _____ Results _____
Date of annual IRGA _____ Results _____
Date of annual IRGA _____ Results _____

FOR INTERNAL USE ONLY
Annual TB screening questionnaire Date_____ Date _____ Date_____ Date_____

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PHYSICIAN/HEALTH CARE FACILITY INFORMATION

TO THE PHYSIAN/HEALTH CARE OFFICIAL: This form will not be accepted if the below information is not completed and signed.

Physician/Provider Name (Print):_____

Signature:_____ Title:_____

Address:_____ City:_____ State:_____ Zip:_____

Date:_____ Phone:_____

Revised 3/11/22 References: http://www.immunize.org/catg.d/p2109.pdf; http://www.immunize.org/catg.d/p2017.pdf; http://www.cdc.gov/tb/topic/testing/healthcareworkers.htm