

**ANGELO STATE UNIVERSITY NURSING PROGRAM
STUDENT IMMUNIZATION RECORD**

Name: _____ CID: _____

Current Mailing Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ Date of Birth: _____

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

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): _____

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 IRGA**. *****History of positive TST or IRGA*

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 (IRGA) within the last year

Date of IRGA _____ 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

Annual TB screening questionnaire Date _____ Date _____ Date _____ Date _____

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 _____

PHYSICIAN/HEALTH CARE FACILITY INFORMATION

TO THE PHYSICIAN/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: _____