

UNIVERSITY OF SAINT MARY NURSING DEPARTMENT IMMUNIZATION RECORD

Name _____
Last Name First Name

Date of Birth ____/____/____ Social Security Number ____/____/____ - ____/____ - ____/____/____

REQUIRED

A. Tetanus-Diphtheria-Pertusis

1. Tetanus-Diphtheria or Tetanus-Diphtheria-Pertusis booster must be within the last ten years..... 1. ____/____/____
Mo Yr

B. M.M.R. (Measles, Mumps, Rubella) (two doses required or individual vaccine as noted below)

1. Dose 1 given at 12 months after birth or later and Dose 2 after 1980..... 1. ____/____/____ 2. ____/____/____
Mo Yr Mo Yr

2. Born before 1957 and therefore considered immune: Yes No

C. Measles (Rubeola) (check all that apply)

1. Immunized with live measles vaccine at 12 months after birth or later and after 1980..... 1. ____/____/____ 2. ____/____/____
Mo Yr Mo Yr

2. Has report of positive immune titer. Specify date..... ____/____/____
Mo Yr

3. Had disease confirmed by doctor's records..... ____/____/____
Mo Yr

D. Rubella (German Measles) (clinical history is not acceptable) (check all that apply)

1. Immunized with live vaccine at 12 months after birth or later and after 1980..... 1. ____/____/____ 2. ____/____/____
Mo Yr Mo Yr

2. Has report of positive immune titer. Specify date..... ____/____/____
Mo Yr

E. Mumps (check all that apply)

1. Immunized with live vaccine at 12 months after birth or later and after 1980..... 1. ____/____/____ 2. ____/____/____
Mo Yr Mo Yr

2. Has report of positive immune titer. Specify date..... ____/____/____
Mo Yr

3. Had disease confirmed by doctor's records..... ____/____/____
Mo Yr

F. Two-Step Tuberculosis (PPD required regardless of prior BCG inoculation)

Two step test required unless proof of prior annual testing.

1. Two PPD (Mantoux) tests within the past 12 months (tine or monovac not acceptable)

Step 1. Result: Neg Pos (____ mm induration horizontal diameter)..... ____/____/____
Mo Yr

2nd test within 1-3 weeks after 1st test.

Step 2. Result: Neg Pos (____ mm induration horizontal diameter)..... ____/____/____
Mo Yr

2. Annual TB Test Result: Neg Pos (____ mm induration horizontal diameter)..... ____/____/____
Mo Yr

3. If greater than 5 mm induration, chest X-ray required. X-ray result: Normal Abnormal

4. Quantiferon-TB Gold Serum Test..... Neg Pos..... ____/____/____
Mo Yr

5. Received BCG:..... Yes No **If yes**..... ____/____/____
Mo Yr

G. Hepatitis B 1. ____/____/____ 2. ____/____/____ 3. ____/____/____
Mo Yr Mo Yr Mo Yr

Hepatitis B surface antigen antibody ____/____/____ Reactive Non-reactive
Mo Yr

H. Varicella (Chicken Pox) Hx of Disease..... Yes No..... Vaccinated 1. ____/____/____ 2. ____/____/____
Mo Yr Mo Yr

1. Has report of positive immune titer. Specify date..... ____/____/____
Mo Yr

OPTIONAL

A. Polio

Completed primary series of polio immunization: Yes No Date of last booster..... ____/____/____

Type of vaccine: Live (OPV) Inactivated (IPV) Enhanced Potency (EP-IPV) Mo Yr

B. Meningococcal Meningitis..... ____/____/____
Mo Yr

Health Care Provider

Name _____ Address _____

Signature _____ Phone _____ Date _____