

**Nova Southeastern University Health Professions Division
Immunization Form**

College of Allied Health and Nursing Students -DO NOT MAIL records to your program or admissions. CAHN students must submit all immunization and physical forms to Certified Background/Magnus Health Portal. If you have any questions please contact Student Support at 1-888-666-7788 or email customerservice@certifiedbackground.com

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)

Rubella immunity: (M) ____ (D) ____ (Y) ____ (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 (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 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 will not be required to do anything further but 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 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) ____ or 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.

These immunization records will not expire

Valid for 10yrs

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

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

Must be completed within six months prior to entering the program
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 1-3 weeks after step one.)

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 (1-3 weeks following 1st step)

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:

Yearly update will be required