

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

**A HEALTHCARE PROVIDER'S SIGNATURE IS REQUIRED ON BOTH PAGES ONE AND TWO**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

College Program: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**THE ANTIBODY TITERS FOR THE VACCINES LISTED IN SECTION A MUST BE ATTACHED**

**SECTION A**

**MEASLES, MUMPS, and RUBELLA**

Students must have received two doses of MMR vaccine **or** have serologic immunity to measles and rubella.

MMR vaccine: dose #1 \_\_\_\_ / \_\_\_\_ / \_\_\_\_ dose #2 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

or

Date of Measles titer \_\_\_\_ / \_\_\_\_ / \_\_\_\_      **\*lab result must be attached**      Immune: Yes \_\_\_\_ No \_\_\_\_

Date of Rubella titer \_\_\_\_ / \_\_\_\_ / \_\_\_\_      **\*lab result must be attached**      Immune: Yes \_\_\_\_ No \_\_\_\_

**VARICELLA**

Varicella vaccine : First dose : \_\_\_\_ / \_\_\_\_ / \_\_\_\_ and Second dose: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

or

Varicella IgG Antibody titer: \_\_\_\_ / \_\_\_\_ / \_\_\_\_      **\*lab result must be attached**      Immune: Yes \_\_\_\_ No \_\_\_\_

**HEPATITIS B**

Serologic testing is required for hepatitis B surface antibody. Serologic immunity should be tested 1-2 months after completion of the three dose hepatitis B vaccine series.

Hepatitis B Vaccines: dose #1 \_\_\_\_ / \_\_\_\_ / \_\_\_\_ dose #2 \_\_\_\_ / \_\_\_\_ / \_\_\_\_ dose #3 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**and**

Date of Hep B Surface Antibody \_\_\_\_ / \_\_\_\_ / \_\_\_\_      **\*lab result must be attached**      Immune: Yes \_\_\_\_ No \_\_\_\_

**SECTION B**

**TETANUS-DIPHTHERIA**

Tetanus /Diphtheria / Pertussis (Tdap)\*\*: \_\_\_\_ / \_\_\_\_ / \_\_\_\_      Tetanus / Diphtheria (Td) : \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\*\*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.

**I certify that the information above is complete and accurate to the best of my knowledge:**

Healthcare Provider Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Healthcare Provider Signature \_\_\_\_\_

## TWO STEP TUBERCULOSIS SCREENING

<p><b>STEP ONE:</b>                  Baseline skin test placed: ____ / ____ / ____                  Baseline skin test read: ____ / ____ / ____                  Results in millimeters: _____ mm</p> <p><b>If test is negative proceed with step two.</b></p> <p>If test is positive you do not need to complete step two.                  If test is positive, a copy of your chest x-ray must be attached</p> <p>Prophylactic treatment for positive PPD: Yes ____ No ____</p> <p>Treated with: _____ x _____ months</p> <p>Completed treatment date: ____ / ____ / ____</p>	<p><b>STEP TWO:</b> (1-3 weeks following baseline)                  Skin test placed: ____ / ____ / ____                  Skin test read: ____ / ____ / ____                  Results in millimeters: _____ mm</p> <p>If secondary PPD is positive, a copy of your chest x-ray must be attached</p> <p>Prophylactic treatment for positive PPD: Yes ____ No ____</p> <p>Treated with: _____ x _____ months</p> <p>Completed treatment date: ____ / ____ / ____</p>
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**I certify that the information above is complete and accurate to the best of my knowledge:**

Healthcare Provider Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Healthcare Provider Signature \_\_\_\_\_

Office Phone Number (       ) \_\_\_\_\_

Office Address \_\_\_\_\_

\_\_\_\_\_

**Mandatory Office or Healthcare Provider Stamp:**