

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, mumps and rubella.

MMR vaccine: dose #1 ____ / ____ / ____ dose #2 ____ / ____ / ____

or

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

Date of Mumps 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. The current CDC recommendation states "Healthcare personnel should receive a single dose of Tdap if they have not previously received Tdap regardless of the time since last Td dose."

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
 (Must be completed within six months prior to entering program)

Student Name: _____ Date of birth: _____

****Quantiferon Tuberculosis Testing can be done in lieu of PPD****

A documented negative Quantiferon –TB Gold blood test within 12 months prior to start of program will substitute for two step PPD screening below. I have attached a negative quantiferon –tb gold lab result to this form.

<p>STEP ONE: Baseline skin test placed: ____ / ____ / ____ Baseline skin test read: ____ / ____ / ____ Results in millimeters: _____ mm</p> <p>If test is negative proceed with step two.</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>STEP TWO: (must be at least 7 days and no longer then 12 months from step one PPD) 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:

Return completed form prior to start of program to:

Specific College and/or Program in which you will be enrolling
 NSU Health Professions Division 3200 S. University Drive Ft. Lauderdale, FL 33328