

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

<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: (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>
--	--

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
 Phone 954-262-1101 Fax 954-262-2282