# Ila Faye Miller School of Nursing & Health Professions

## STUDENT IMMUNIZATION RECORD

**NAME** (print or type): _____ **Date of Birth:** _____

**UIW ID#:** _____ **Contact Phone #:** _____

**Program entering:** □ **Undergraduate** □ **Graduate**

**HEPATITIS B ONLY *OR* HEPATITIS A&B COMBO VACCINE**

D A T E: 1.)_____ 2.)_____ 3.)_____

***AND***

Hepatitis B Antibody Titer: Date:_____ Immune:_____ Not Immune:_____ Value:_____

**TUBERCULOSIS (TB Screen/PPD)**

Date Placed:_____ Date Read:_____ Results: _____mm _____Positive _____Negative

***OR***

**QUANTIFERON TB GOLD *or* TSpot**

Results: _____Positive _____Negative

**If positive reading**

CXR Results:_____ Date:_____

***For office use only***
Current TB screening or TB Physical exam:

| | | |
|---|---|---|
| Date:_____ | Date:_____ | Date:_____ |
| Date:_____ | Date:_____ | Date:_____ |

**VARICELLA (Chickenpox)**

1ST Immunization date:_____ 2nd Immunization date:_____

***OR***

Varicella Titer Date:_____ Immune:_____ Not Immune:_____ Value:_____

**MEASLES (RUBEOLA), MUMPS, and RUBELLA**

1st Immunization Date:_____ 2nd Immunization Date:_____

***O R***

| | | | |
|---|---|---|---|
| Measles Titer Date:_____ | Immune:_____ | Not Immune:_____ | Value:_____ |
| Mumps Titer Date:_____ | Immune:_____ | Not Immune:_____ | Value:_____ |
| Rubella Titer Date:_____ | Immune:_____ | Not Immune:_____ | Value:_____ |

**Tdap** **(Tetanus, Diphtheria, & Pertussis)**

Booster Date:_____

**FLU** **(During current flu season only)**

Date:_____

***For office use only***
Seasonal flu vaccine

| | | |
|---|---|---|
| Date:_____ | Date:_____ | Date:_____ |
| Date:_____ | Date:_____ | Date:_____ |

**By signing below, I certify that the information above is true and correct:**

PROVIDER NAME (print):_____ Title (RN, APRN, PA, MD, or DO): _____

Signature:_____ Date:_____

Daytime Phone: (____)_____ __

***For office use only***
Reviewer signature:_____ Date:_____