Samford University
Moffett & Sanders School of Nursing

IMMUNIZATION RECORD

Required of all MSSON Undergraduate Nursing Students

Name: _____
Last *First* *MI*

SU Email address: _____ **Date of Birth:** _____/_____/_____

Phone number: (____) _____-_____

Enrolling: ☐Fall ☐ Spring Year 20___

Living in Campus Housing? Yes [ ] No [ ]

Immunization history must be completed and signed by a health care provider and uploaded by the student to their compliance account by the stated deadline.

VACCINATIONS REQUIRED OF ALL STUDENTS:

M.M.R. (Measles, Mumps and Rubella)
Born before 1957, no MMR immunization required
Combined Vaccines (Two doses; at least one month apart)

M.M.R (Measles,Mumps,Rubella)	#1 ____/____/_____ month/ day/ year	#2 ___/____/__ month/day/year

OR

Individually Administered Vaccines

Measles	#1 ___/____/_____ month/day/year	#2 ____/____/____ month/day/year
Mumps	#1 ___/____/_____ month/day/year	
Rubella	#1 _____ month/day/year	

OR

Laboratory Evidence of Immunity (all 3 required) in lieu of vaccines
*must submit copy of lab report
*if not immune, please complete the vaccination series

Measles	#1 ___/____/_____ month/day/year	Result: Immune or Non-Immune
Mumps	#1 ___/____/_____ month/day/year	Result: Immune or Non-Immune
Rubella	#1 ___/____/_____ month/day/year	Result: Immune or Non-Immune

Tdap (TETANUS-DIPHTHERIA-ACELLULAR PERTUSSIS)

At least one dose required within the last 10 years	_____/_____/_____ month/ day/ year

VARICELLA (Chickenpox)

History of Disease	/ / Month Day Year (Minimum Month/Year as date accepted please provide laboratory evidence of immunity if date not available)	**OR**	Immunizations (Two doses required)	#1 / / Month Day Year	#2 / / Month Day Year

OR

Laboratory Evidence of Immunity*
/ /
Month Day Year
RESULT:
[ ] Immune
[ ] Non-Immune

*must provide copy of lab report
*if not immune, please complete the vaccination series

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VACCINATIONS REQUIRED

INFLUENZA (required between September and August)

*** This section is only completed by students who enter their first clinical semester in January, students entering their first clinical semester in August will receive the flu vaccine for that year after the form submission deadline has passed, those students will upload proof of flu vaccination to their compliance account using a different form.**

Immunization	/ / Month Day Year

HEPATITIS B

Immunizations

#1 / / Month Day Year	#2 (at least one month after dose #1) / / Month Day Year	#3 (at least six months after dose #1 OR four months after dose #2) / / Month Day Year

OR

Laboratory Evidence of Immunity*

Hepatitis B Surface Antibody *(*must provide copy of lab report)*	/ / Month Day Year	RESULT: [ ] Immune [ ] Non-Immune

THIS SECTION TO BE FILLED OUT BY HEALTH CARE PROVIDER ONLY (within 2 months prior to the of beginning clinical rotations)

Student Health Information

□ Please list any potential communicable illnesses: _____

_____

_____

_____

MD/DO/PA/NP/CRNP/RN Signature: _____ Date: _____

Licensed Healthcare Provider's Printed Name and Credentials: _____

Facility Name and Address: _____

City: _____ State: _____ Zip Code: _____ Phone: (_____) _____-_____

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Patient _____
LAST *FIRST* *MI*

TUBERCULOSIS SCREENING:

The Moffett & Sanders School of Nursing at Samford University requires a two-step Tuberculosis skin test (TST), or an IGRA blood test for all students within 60 days of beginning clinical rotations. If you have received the BCG vaccine, an IGRA blood test is preferred. If you have a history of a positive Tuberculosis skin test (TST) ≥10mm or positive IGRA blood test please supply information regarding any evaluation and/or treatment below. Guidelines are based upon the recommendation for Tuberculosis screening for healthcare providers by the CDC. Tuberculosis screening must be completed within 2 months prior to the beginning of clinical rotations.

The two-step Tuberculosis skin test requires 4 separate appointments and must be administered between one (1) and three (3) weeks apart.

Section A		**Date Placed**	**Date Read**	**Reading**
Must be completed by all students with no prior history of Tuberculosis, prior positive TST or positive IGRA blood test	TST #1	_____/____/_____	_____/____/_____	_____ mm
	TST #2	_____/____/_____	_____/____/_____	_____ mm
	IGRA Blood Test □ T-spot □ Quantiferon Gold		□ Attach copy	

Section B		**Date Placed**	**Date Read**	**Reading**
Only completed by students with a history of Latent Tuberculosis, Positive 2-step TST, or positive IGRA blood test	Positive TST	_____/____/_____	_____/____/_____	_____ mm
	Positive IGRA Blood Test	**Date** _____/____/_____	**Type Test** □ T-spot □ Quantiferon Gold	□ Attach copy
	Chest X-ray	_____/____/_____	□ Attach copy	
	Prophylactic medications for latent TB taken?		□ Yes □ No	
	Total duration of prophylaxis?		_____ months	
	Date of last annual TB symptom questionnaire (if applicable)		_____/____/_____	

Section C			
Only completed by students with a history of active tuberculosis	Date of Diagnosis	_____/____/_____	□ Attach copy
	Date Treatment Completed	_____/____/_____	□ Attach copy
	Date of last annual TB symptom questionnaire (if applicable)	_____/____/_____	□ Attach copy
	Date of last Chest X-ray	_____/____/_____	□ Attach copy

MD/DO/PA/NP/CRNP/RN/LPN Signature: _____ **Date**: _____

Licensed Healthcare Provider's Printed Name and Credentials: _____

Facility Name and Address: _____

City: _____ State: _____ Zip Code: _____ Phone: (_____) _____-_____

Tuberculosis screening form must be completed and signed by a health care provider (MD, DO, NP/CRNP, PA, RN) and uploaded by the student to their compliance account.