Central Community College Health Sciences
Immunization Record

Student name: _____ Date: _____
(Please Print)

Date of Birth: _____ Age: _____

MEASLES/MUMPS/RUBELLA (MMR)

For individuals born after Jan. 1957

One of the following is required:

Two required Immunizations:

#1 Date: _____

#2 Date: _____

Or Positive Titer:

Measles Positive Titer - Date: _____

Mumps Positive Titer - Date: _____

Rubella Positive Titer - Date: _____

VARICELLA (Chickenpox)

Two required immunizations:

#1 Date: _____

#2 Date: _____ Or Positive antibody titer: Date: _____

TETANUS/DIPHTHERIA/PERTUSSIA (Tdap)

Documentation of Tdap immunization **within the past 10 years:**

(If Tdap has not been previously administered to the student an interval of 2 years since the last TD booster is suggested.)

Date: _____

HEPATITIS B

Hepatitis B # 1 - Date: _____ Or Positive Antibody Titer - Date: _____

Hepatitis B # 2 - Date: _____ *If titer is negative, repeat the serries and titer

Hepatitis B # 3 - Date:

TUBERCULOSIS SKIN TEST (PPD)

Initial 2-step screening - 2 separate PPD skin tests given and read at least 1 week apart OR 2 tests in a 12 month period

Annual PPD screening after 2-step requirement met.

Results DATE # 1 _____ DATE # 2 _____

Circle one POSITIVE NEGATIVE POSITIVE NEGATIVE

If positive tuberculin skin test, documentation should include chest x-ray results and medical treatment received

Chest X-ray & Medications/Treatment - Date:

INFLUENZA VACCINE (YEARLY) **Must have documentation from provider**

Vaccine Name: _____ Lot #: _____ Date: _____

COVID - 19 **Must have documentation from provider**

	1st Dose		2nd Dose
Manufacturer	_____	Manufacturer	_____
Date		Date	

TB testing is required yearly prior to first clinical rotation. Influenza vaccine is required yearly.

RETURN FORM TO: Central Community College, Pre-Nursing Advisor

Attach copies of immunization records **or** provide physicians signature verifying immunizations.

Physician's Signature: _____ Date: _____