



## Practical Nursing Program Student Record of Immunization Form

Student Name	Student Date of Birth
Address	Phone

**Directions for completing form:**

Enter the month and year for each of the boxes listed. All the boxes must be filled in for this form to be valid with the exception of pending Hepatitis B doses #2 and/or #3. Subsequent documentation of completed doses 2 and 3 must be provided to the nursing program if not complete at time of application.

Student Immunization Record			
Measles (Rubeola /Red measles)/ Mumps/ Rubella (German measles) 2 doses required after age 12 months or proof of immunity by titer	Month/Year	Month/Year	
Varicella (Chickenpox) 2 doses after age 12 months or proof of immunity by titer	Month/Year	Month/Year	
Tetanus/Diphtheria (Td) or Tetanus/Diphtheria/Pertussis (TdaP) 1 dose at/after age18 years	Month/Year		
Hepatitis B 3 doses or proof of immunity by titer At least 2 doses required in Semester 1 of program. At least 1 dose required for admission.	Month/Year Dose 1	Month/Year Dose 2	Month/Year Dose 3

*For the practitioner:* I verify that the above information is true and an accurate statement of the dates on which the student received immunizations or showed laboratory evidence of immunity.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Clinic name:** \_\_\_\_\_

**Clinic Address:** \_\_\_\_\_

***A stamp from the clinic is required:***