

**ANDERSON UNIVERSITY SCHOOL OF NURSING
IMMUNIZATION RECORD**

NAME: _____ **DATE OF BIRTH** _____

MUST BE COMPLETED BY A HEALTHCARE PROVIDER

<p>1. Rubella (German Measles) Must have proof of one dose of vaccine OR a positive titer.</p>	<p>Immunization date: _____ Titer results: _____ Date: _____</p>
<p>2. Rubeola (Measles)—All persons born on or after 1/1/57 must show proof of 2 measles vaccination OR a positive titer OR documentation of disease by a physician.</p>	<p>Immunization date #1: _____ Immunization date #2: _____ Titer results: _____ Date: _____ History of disease (circle one): YES NO</p>
<p>3. Mumps—Immunization OR titer OR history of disease</p>	<p>Immunization date: _____ Titer results: _____ Date: _____ History of disease (circle one): YES NO</p>
<p>4. Tetanus and Diptheria—Primary series in childhood.</p>	<p>Immunization date #1: _____ Immunization date #2: _____ Immunization date #3: _____ Immunization date #4: _____</p>
<p>5. Tetanus—booster within past 10 years required</p>	<p>Date: _____</p>
<p>6. Polio—Primary series in childhood.</p> <ul style="list-style-type: none"> • If you were vaccinated for polio but are unable to provide documentation, you are required to provide documentation of one polio injection (IPV). • If you were never vaccinated for polio, you are required to provide documentation of completion of a series of 3 polio injections over the period of 6 months. 	<p>Immunization date #1: _____ Immunization date #2: _____ Immunization date #3: _____</p> <p>IPV: _____ (if indicated)</p>
<p>7. Chicken Pox—must have had the disease OR positive Varicella antibody OR have had 2 doses of Varicella vaccine.</p>	<p>History of disease (circle one): YES NO</p> <p>Vaccine #1: _____ Vaccine #2: _____</p> <p>Titer: _____ Date: _____</p>
<p>8. TB screening (Mantoux) (Must be updated annually, within 3 months of the beginning of the Fall Semester) **If there is a past history of a positive PPD, a chest x-ray is required.</p>	<p>Results: _____ Date read: _____</p> <p>Results of Chest x-ray: _____ (if indicated)</p>
<p>9. Hepatitis B Vaccine—Three doses OR positive antibody required. Signed waiver must be on file until series is completed.</p> <p>For office use only: In process: _____ Waiver on file _____</p>	<p>Dose 1: _____ Dose 2: _____ Dose 3: _____</p> <p>HbsAB results: _____ Date: _____</p>
<p>Healthcare Provider's signature: Address & Phone number:</p>	

****It is important that you keep a copy for your own records before turning in to AU School of Nursing.
*** AUSON reserves the right to charge a fee for copies of this form after it is submitted to our office.**