Vocational Nursing Program

Immunizations and Tests
Required by State Law/Clinical Facilities

Name: _____ **TSTC ID#:** _____

Program: _____ **Date of Birth:** _____

In addition to the other vaccines listed below, proof of **Tuberculosis Skin Test (PPD skin test or chest x-ray report)** with a negative reading is required with the submission of application. (Test may not be more than 180 days old on the first day of class.) Date: _____ Results: _____

Measles (Rubeola),Mumps, Rubella: ALL students must show proof of either:	
A. Two doses of MMR vaccine on or after their first birthday and at least 30 days apart OR *See note.	Date #1 _____ (mm/dd/yy) Date #2 _____ (mm/dd/yy)
B. Serologic test positive for measles, mumps, and rubella antibodies (Copies of test results required.) **See note.	Date _____ (mm/dd/yy)
*Combined MMR Vaccine is vaccine of choice if recipients are likely to be susceptible. **Must be the date of diagnosis or test collection; not when primary care provider signed immunization form. +Vaccines administered after September 1, 1991 shall include the MM/DD/YY each vaccine was given.	
Hepatitis B must show proof of:	
A. Three doses of vaccine	Date #1 _____ (mm/dd/yy) Date #2 _____ (mm/dd/yy) Date #3 _____ (mm/dd/yy)
B. Serologic test positive for Hepatitis B antibody **See note. (Copies of test results required.)	Date _____ (mm/dd/yy) Result _____
Hepatitis A must show proof of:	
A. Two doses of vaccine	Date #1 _____ (mm/dd/yy) Date #2 _____ (mm/dd/yy)
B. Serologic test positive for Hepatitis A antibody **See note. (Copies of test results required.)	Date _____ Result _____ (mm/dd/yy)

Varicella must show proof of:	
A. Two doses of Varicella vaccine administered 4-8 weeks apart OR	Date #1 _____ (mm/dd/yy) Date #2 _____ (mm/dd/yy)
B. Serologic test positive for Varicella antibody OR **See note. (Copies of test results required.)	Date _____ (mm/dd/yy) Results _____
C. Physician or parent documented history or diagnosis of Varicella **See note.	Date Disease Occurred _____ (mm/dd/yy)
*Only one dose of Varicella vaccine is needed if the student received first dose before the age of thirteen (13).	
Tetanus, Diphtheria and Acellular Pertussis (Tdap): One dose within past 10 years at the time of application	Date _____ (mm/dd/yy)
Meningococcal vaccine One dose MCV4 ***For ages 2-55 years**	Date _____ (mm/dd/yy)

Physician or Approved Licensed Health Professional Information:	
Printed Name	
Address	
Signature of Primary Care Provider	Date