



## 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)
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B. Serologic test positive for measles, mumps, and rubella antibodies (Copies of test results required.) **See note.	Date _____ (mm/dd/yy)
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\*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)
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B. Serologic test positive for Hepatitis B antibody **See note. (Copies of test results required.)	Date _____ (mm/dd/yy)      Result _____
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**Hepatitis A** must show proof of:

A. Two doses of vaccine	Date #1 _____ (mm/dd/yy) Date #2 _____ (mm/dd/yy)
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B. Serologic test positive for Hepatitis A antibody **See note. (Copies of test results required.)	Date _____ (mm/dd/yy)      Result _____
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<b>Varicella</b> must show proof of:	
A. Two doses of Varicella vaccine administered 4-8 weeks apart OR	Date #1 _____ Date #2 _____ (mm/dd/yy) (mm/dd/yy)
B. Serologic test positive for Varicella antibody OR **See note. (Copies of test results required.)	Date _____ Results _____ (mm/dd/yy)
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).	
<b>Tetanus, Diphtheria and Acellular Pertussis (Tdap):</b> One dose within past 10 years at the time of application	Date _____ (mm/dd/yy)
<b>Meningococcal vaccine</b> One dose MCV4 *For ages 2-55 years	Date _____ (mm/dd/yy)

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