

ANGELO STATE UNIVERSITY NURSING PROGRAM STUDENT IMMUNIZATION RECORD

Name _____ Date _____
Print or Type Last First Middle

Current Mailing Address _____ Daytime Phone (____) _____
Street

City/State _____ Zip _____

CID _____ Date of Birth _____

PROGRAM ENTERING: (please check one) AASN Generic BSN RN – BSN MSN RN – MSN

IMMUNIZATION HISTORY

The section below must be completed by a **physician or health care facility official** and **signed** on the bottom of this form.
NOTE: Do not submit if incomplete. This form will not be accepted if any immunizations are left blank. No attachments necessary*.
(*Please do not send this form in blank with a shot record attached. It will be sent back to be completed.)

HEPATITIS B (may take up to 6 months to complete series)
Nursing students are required to have the Hepatitis B vaccine series. If the student has received the Hepatitis B vaccine series, please certify the following. If vaccine series was completed more than 10 years ago, a quantitative AB titer is needed.
Name of vaccines received: _____ Date of vaccine _____
1. _____
2. _____
3. _____
Post-vaccine quantitative antibody titer: _____ Date/Results _____

TUBERCULOSIS
A Skin Test intermediate strength PPD is required for all students **within the calendar year of admission** and annually thereafter.
Date of Skin Test Reading: _____ Results: _____
If PPD is positive, date & result of most recent Chest X-ray (**must be within the calendar year.**): _____

VARICELLA (Chicken Pox)
All students must submit one of the following:
Documentation of two immunizations administered on or after their first birthday and at least 30 days apart. OR
Laboratory report of positive immune serum antibody titer (IGG).
Date of first immunization: _____
AND
Date of second immunization: _____
OR
Date & result of Varicella titer: _____

DIPHTHERIA-TETANUS (Td)
Proof of booster shot within the past 10 years is required.
Date of Diphtheria-Tetanus booster: _____

MEASLES (Rubeola)
All students must submit one of the following:
a) Signed physician's record documenting two (2) immunizations administered on or after their first birthday and at least 30 days apart. OR
b) Laboratory report of positive immune serum antibody titer (IGG).
Date of first immunization: _____
AND
Date of second immunization: _____
OR
Date & result of Rubeola titer: _____

MUMPS
All students must submit one of the following:
a) Signed physician's record documenting immunization.
b) Laboratory report of positive immune serum antibody titer (IGG).
Date of Mumps vaccine: _____
OR
Date & result of Mumps titer: _____

RUBELLA
All students must submit one of the following:
a) Signed physician's record documenting immunization.
b) Laboratory report of positive immune serum antibody titer (IGG).
Date of Rubella vaccine: _____
OR
Date & result of Rubella titer: _____

MENINGITIS (optional)
Date of vaccination: _____
Decline vaccination (Init): _____

PHYSICIAN/HEALTH CARE FACILITY INFORMATION

TO THE PHYSICIAN/HEALTH CARE OFFICIAL: This form will not be accepted if the below information is not completed and signed.

Physician/Provider Name (Print) _____

Address _____ Phone (____) _____
Street City/State Zip

Title (M.D., D.O., P.A., N.P., RN, LVN) _____ Date _____ SIGNATURE _____