



## 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:

<p>A. Three doses of MMR vaccine on or after their first birthday and at least 30 days apart OR *See note.</p>	<p>Date #1 _____ Date #2 _____ (mm/dd/yy) (mm/dd/yy)</p> <p>Date #3 _____ (mm/dd/yy)</p>
<p>B. Serologic test positive for measles, mumps, rubella antibodies (Copies of test results required.) **See note.</p>	<p>Date _____ (mm/dd/yy)</p>

\*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:

<p>A. Three doses of vaccine</p>	<p>Date #1 _____ (mm/dd/yy)</p> <p>Date #2 _____ (mm/dd/yy)</p> <p>Date #3 _____ (mm/dd/yy)</p>
<p>B. Serologic test positive for Hepatitis B antibody **See note. (Copies of test results required.)</p>	<p>Date _____ Result _____ (mm/dd/yy)</p>

**Hepatitis A** must show proof of:

<p>A. Two doses of vaccine</p>	<p>Date #1 _____ (mm/dd/yy)</p> <p>Date #2 _____ (mm/dd/yy)</p>
<p>B. Serologic test positive for Hepatitis A antibody **See note. (Copies of test results required.)</p>	<p>Date _____ Result _____ (mm/dd/yy)</p>

<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