

**Associate Degree Nursing ProgramHealth Science Division**

**Immunizations and Tests**

**Required by Texas State Department of Health Services/Clinical Facilities**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Measles (Rubeola)\*:**

A. **Two** doses of measles-containing vaccine

 **o**n or afterJanuary 1, 1968 and at least Date#1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date#2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

30 days apart **OR** (mm/dd/yy) (mm/dd/yy)

B. Serologic test positive for measles antibody\*\* Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (mm/dd/yy)

**Mumps**\*:

A. Onedose of mumps vaccine on or after

January 1, 1957 **OR** Date#1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date#2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yy) (mm/dd/yy)

B. Serologic test positive for mumps antibody\*\* Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (mm/dd/yy)

**Rubella\*:**

A. **One** dose of rubella vaccine on or after

the first birthday **OR** Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (mm/dd/yy)

B. Serologic test positive for rubella antibody\*\* Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (mm/dd/yy)

**\*Combined MMR Vaccine is vaccine of choice if recipients are likely to be susceptible**

**\*\*Must include date of test collection**

**Hepatitis B: (3 doses)**

A. The minimum interval between the first two

 doses is 4 weeks, and the minimum Date #1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 interval between the second and third (mm/dd/yy)

 doses is 8 weeks. However, the first and Date #2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 third doses should be separated by no less (mm/dd/yy)

 than 16 weeks. It is not necessary to restart Date #3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 the series or add doses because of an (mm/dd/yy)

 extended interval between doses. **OR**

B. Serologic test positive for Hepatitis B antibody Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Must include date of test collection** (mm/dd/yy)

**Note: An accelerated dosing schedule with Twinrix vaccine (Hepatitis A and Hepatitis B recombinant) may be an option to meet Texas DSHS requirements for Hepatitis B immunization.**

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Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Varicella:**

A. **Two** doses of varicella vaccine Doses must be at least 28 days apart.

 Date#1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date#2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **OR** (mm/dd/yy) (mm/dd/yy)

B. Serologic test positive for varicella antibody

 Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Must include date of test collection** (mm/dd/yy)

**Td/Tdap:**

**One** dose of a tetanus-diptheria (Td) is required within the Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

last ten (10) years. The booster dose may be in the form (mm/dd/yy)

of a tetanus-diptheria-pertussis containing vaccine (Tdap).

**Physician or Approved Licensed Health Professional Information:**

Printed Name

Address

Signature of Primary Care Provider Date

**Signature validates all information on this form. Date of signature must be after last immunization or additional immunizations must be signed and dated separately.**

**Note: All vaccines administered after September 1, 1991 shall include the MM/DD/YY that each vaccine was given.**