ST. JOSEPH'S COLLEGE OF NURSING
at St. Joseph's Hospital Health Center

IMMUNIZATION REQUIREMENTS

(Section 405.3 – Title 10 DOH)

NAME________________________________**DOB**____________________________________

Requirement	Documentation
Must submit documentation of receiving two (2) **MMR Vaccines** after age 12 months, the second being given no sooner than 28 days after the first. ***OR*** Positive Rubella, Rubeola and Mumps titer with copy of serology (lab copy)	First MMR*:* _____/_____/_____ Second MMR*:* _____/_____/_____ ***OR*** Titers attached: Yes / No
Documentation of history of disease with **VARICELLA** ***OR*** Receipt of two (2) Varivax vaccine dates ***OR*** Positive titer with copy of serology	Past disease history: ___Yes ___No VARIVAX: First dose ____/____/____ Second dose____/____/____
TUBERCULOSIS MANTOUX TEST (PPD): within the past six (6) months. **History of a positive TB test requires a copy of a negative chest x-ray report completed within the past three years.	Date of PPD: ____/____/____ Results: ________________________________ CXR date if +PPD:_______________________
MENINGOCOCCAL VACCINE: **Must** provide date of vaccine **within 5 years,** OR sign to decline in adjacent column. DATE:_______________________ Circle type: MENACTRA MENOMUNE	I have read or had explained to me, information regarding meningococcal disease (meningitis) and have decided not to obtain the vaccine. I understand the risks of this decision. ______________________________________ **Student signature** (parent/guardian) if <18yrs age)
Tdap: Tetanus, Diptheria Pertussis	Date: ____________________________________
HEPATITIS B: List the dates of the vaccine series or include a copy of a lab titer regardless of results.	Date of first dose: _____/_____/_____ Date of second dose: _____/_____/_____ Date of third dose: _____/_____/_____

******An influenza vaccine will be required annually in the fall when available. Only medical exemptions will be accepted for declination.***