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

IMMUNIZATION REQUIREMENTS

(Section 405.3 – Title 10 DOH)

NAME_____ **DOB**_____

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): _____ **One of the following is required from within the past 12 months:** **2 step TB skin test (administered 2-3 weeks apart) along with the completed TB screening questionnaire.** • **Two step PPD process:** • **1st TB Skin test (PPD) prior to beginning school** • **2nd TB Skin Test 2-3 weeks after the 1st TB placement** **OR** • **QuantiFERON Gold Blood test along with the completed TB screening questionnaire** **OR** • **If you have positive test results, please provide BOTH of the following:** • **a clear chest x-ray report from within the last 3 years** **AND** • **completed TB screening questionnaire** **The renewal date will be set for 1 year.** **Upon renewal, one of the following is required:** • **2 step TB skin test (administered 2-3 weeks apart) along with the completed TB screening questionnaire** • **Two step PPD process:** • **1st TB Skin test (PPD) prior to beginning school** • **2nd TB Skin Test 2-3 weeks after the 1st TB placement** **OR** • **If you previously submitted a QuantiFERON Gold Blood test or chest x-ray, please submit the completed TB screening questionnaire.** **TB screening questionnaire is available for download from this requirement.**	Date of PPD: #1: __/__/____ #2: __/__/____ 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, Diphtheria 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.**