Nursing Assistant I Program
Workforce & Community Engagement
Student Checklist – Immunization Requirements

Every student must provide proof of immunizations and have it approved through Complio, prior to the first day of class. Please refer to your healthcare provider for a copy of your immunization record. Students can decide to use the immunization form provided by the College (see pages 2 and 3). It must be signed by an authorized medical professional and attested to by the student.

_____ **Measles, Mumps, Rubella (MMR)**

- Documentation of 2 measles vaccines, 2 mumps vaccines and 1 rubella vaccine
  OR
  Documentation of positive titers (blood test) showing immunity
  OR
- If no documentation, 2 measles vaccines, 2 mumps vaccines and 1 rubella vaccine is required

_____ **Varicella (Chicken Pox)**

- Documentation of 2 varicella vaccines if never had chicken pox
  OR
- Documentation of varicella positive titers (blood test) showing immunity if history of chicken pox

_____ **Hepatitis B**

- Documentation of 3 Hepatitis B vaccines
  OR
  Documentation of Hepatitis B positive titers (blood test) showing immunity
  OR
- Documentation of 2 dose Heplisav-B

_____ **Tetanus, Diphtheria, Pertussis (Td/Tdap)**

- Documentation of a Td/Tdap that is current, within the past 10 years
- Individuals should receive booster every 10 years

_____ **Tuberculosis (TB) Screening**

- An IGRA (QuantiFERON or T-Spot) annually. Your IGRA must be within the past 8 months, prior to the program start date
- If you test positive for tuberculin exposure, you must submit a negative chest x-ray within the last 5 years
- TB clearance letters must be dated no more than 8 months before your program start date

_____ **Quadrivalent Flu (Influenza)**

- Proof of seasonal flu vaccine.
- For medical exemptions: Medical contraindications must be reported on a physician letterhead.
- For religious/personal exemptions: A letter from you indicating your beliefs must be provided.

_____ **Coronavirus (COVID-19)**

- 1 dose of either the Pfizer, Moderna, AstraZeneca, or Johnson & Johnson COVID-19 vaccine
- For medical exemptions: Medical contraindications must be reported on a physician letterhead.
- For religious/personal exemptions: A letter from you indicating your beliefs must be provided.

Davidson-Davie
COMMUNITY COLLEGE

Name:____ SS# or Student ID:________________ Date of Birth: ______________
Last First Middle/Maiden MM/DD/YYYY

Student Immunization Form

(Must be completed by MD/PA/NP/RN/Health Dept. Representative)

Measles Vaccine or MMR	**OR**	**Measles Antibody**
Date 1: ____/____/____ Date 2: ____/____/____		Date: ____/____/____ Results: ☐ Positive ☐ Negative
Mumps Vaccine	**OR**	**Mumps Antibody**
Date 1: ____/____/____ Date 2: ____/____/____		Date: ____/____/____ Results: ☐ Positive ☐ Negative
Rubella Vaccine	**OR**	**Rubella Antibody**
Date: ____/____/____		Date: ____/____/____ Results: ☐ Positive ☐ Negative
Varicella Vaccine	**OR**	**Varicella Antibody**
Date 1: ____/____/____ Date 2: ____/____/____		Date: ____/____/____ Results: ☐ Positive ☐ Negative

Tetanus		
Td	**OR**	**Tdap**
Date: ____/____/____ (required every 10 years)		Date: ____/____/____ (required every 10 years)

Tuberculosis (TB) Screening	
☐ QuantiFERON-TB Gold ☐ T-SPOT.TB Date: ____/____/____ Results: ☐ Positive ☐ Negative	If positive, CXR date and result: ________ Treatment: ________ Date of Chest X-Ray: ___/___/___ Results: ______

Hepatitis B		
Vaccine	**OR**	**Antibody**
Date 1: ____/____/____ Date 2: ____/____/____ Date 3: ____/____/____		Date: ____/____/____ Results: ☐ Positive ☐ Negative

____________________ ________ ( ) ____________
Health Care Provider Signature/Stamp **(Required)** **Date** **Telephone Number** **(Required)**

Address of Medical Facility **(Required):**

____________________ __________ ______ ______
Street **City** **State** **Zip Code**

Name:________________________________ SS# or Student ID:______________ Date of Birth: ____________

Last First Middle/Maiden MM/DD/YYYY

Seasonal Flu	
Date:_________/_________/_________ (required every year)	
COVID-19	
Initial Round and/or Single-Dose	Booster(s)
Date:_________/_________/_________ Manufacturer: ☐ Pfizer ☐ Moderna ☐ AstraZeneca ☐ Johnson & Johnson Date:_________/_________/_________ Manufacturer: ☐ Pfizer ☐ Moderna ☐ AstraZeneca ☐ Johnson & Johnson	Date:_________/_________/_________ Manufacturer: ☐ Pfizer ☐ Moderna ☐ AstraZeneca ☐ Johnson & Johnson Date:_________/_________/_________ Manufacturer: ☐ Pfizer ☐ Moderna ☐ AstraZeneca ☐ Johnson & Johnson

Additional Information:

Measles, Mumps, Rubella (MMR) – Must provide:

- Documentation of 2 measles vaccines, 2 mumps vaccines and 1 rubella vaccine **OR**
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- If no documentation, 2 measles vaccines, 2 mumps vaccines and 1 rubella vaccine is required

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Hepatitis B – Must provide:

- Documentation of 3 Hepatitis B vaccines **OR**
- Documentation of Hepatitis B positive titers (blood test) showing immunity **OR**
- Documentation of 2 dose Heplisav-B **OR**

Tetanus, Diphtheria, Pertussis (Td/Tdap) – Must provide:

- Documentation of a Td or Tdap that is current within 10 years
- Individuals should receive booster every 10 years

Tuberculosis (TB) Screening – Must provide:

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COVID-19 – Must provide:

- 1 dose of the Pfizer, Moderna, AstraZeneca, or Johnson and Johnson vaccine
- For medical exemptions: Medical contraindications must be reported on a physician letterhead.
- For religious/personal exemptions: A letter from you indicating your beliefs must be provided.

Student Attestation

I hereby attest to this document being true and accurate. I understand the program clinical expectations and affirm to factual representation of my immunization record. Any false reporting will be subject to review and disciplinary action in accordance with institutional policies up to an including termination from the program.

____ ____________________

Student Signature (Required) **Date**