Davidson-Davie COMMUNITY COLLEGE

Health & Wellness Programs
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 or Tdap that is current within 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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Varicella (Chicken Pox) – Must provide:
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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
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Tuberculosis (TB) Screening – Must provide:
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- Proof of seasonal flu vaccine.
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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**

Workforce & Community Engagement, Health & Wellness Programs