



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

Every student must provide proof of immunizations and have it approved, prior to being cleared to enroll. 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.
- **Note:** Exemptions are processed in accordance with and based upon the policies of clinical facilities; therefore, exemptions are not guaranteed.

_____ **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.
- **Note:** Exemptions are processed in accordance with and based upon the policies of clinical facilities; therefore, exemptions are not guaranteed.



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: _____/_____/_____	
Date 2: _____/_____/_____			Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Mumps Vaccine		OR	Mumps Antibody	
Date 1: _____/_____/_____			Date: _____/_____/_____	
Date 2: _____/_____/_____			Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Rubella Vaccine		OR	Rubella Antibody	
Date: _____/_____/_____			Date: _____/_____/_____	
			Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Varicella Vaccine		OR	Varicella Antibody	
Date 1: _____/_____/_____			Date: _____/_____/_____	
Date 2: _____/_____/_____			Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Tetanus				
Td		OR	Tdap	
Date: _____/_____/_____			Date: _____/_____/_____	
(required every 10 years)			(required every 10 years)	
Tuberculosis (TB) Screening				
<input type="checkbox"/> QuantiFERON-TB Gold <input type="checkbox"/> T-SPOT.TB Date: _____/_____/_____		If positive, CXR date and result: _____ Treatment: _____ Date of Chest X-Ray: _____/_____/____ Results: _____		
Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative				
Hepatitis B				
Vaccine		OR	Antibody	
Date 1: _____/_____/_____			Date: _____/_____/_____	
Date 2: _____/_____/_____			Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Date 3: _____/_____/_____				

Health Care Provider Signature/Stamp (Required)

Date

() _____
Telephone Number (Required)

Address of Medical Facility (Required):

Street
Workforce & Community Engagement, Health & Wellness Programs

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: <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> AstraZeneca <input type="checkbox"/> Johnson & Johnson	Date: _____/_____/_____ Manufacturer: <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> AstraZeneca <input type="checkbox"/> Johnson & Johnson
Date: _____/_____/_____ Manufacturer: <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> AstraZeneca <input type="checkbox"/> Johnson & Johnson	Date: _____/_____/_____ Manufacturer: <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> AstraZeneca <input type="checkbox"/> Johnson & Johnson

Additional Information:

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COVID-19 – Must provide:

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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