



**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

_____ **QuantiFERON Gold (IGRA)**

- An IGRA (QuantiFERON) test 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.
- Religious and personal exemptions will not be considered.



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: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Mumps Vaccine		OR	Mumps Antibody
Date 1: ____/____/____ Date 2: ____/____/____			Date: ____/____/____ 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 2: ____/____/____			Date: ____/____/____ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Tetanus			
Td		OR	Tdap
Date: ____/____/____ (required every 10 years)			Date: ____/____/____ (required every 10 years)
Tuberculosis (TB) Screening			
<input type="checkbox"/> QuantiFERON-TB Gold Date: ____/____/____ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative (SKIN TEST NOT ACCEPTED)		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: <input type="checkbox"/> Positive <input type="checkbox"/> 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 (Required for Fall and Winter Sessions)

Date: _____/_____/_____
(required every year)

Additional Information:

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

- 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) – Must provide:

- 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 – 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:

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

Quadrivalent Flu (Influenza) – Must provide:

- Proof of seasonal flu vaccine.
- For medical exemptions: Medical contraindications must be reported on a physician letterhead.
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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 and including termination from the program.

Student Signature (Required)

Date