**SINTE GLESKA UNIVERSITY NURSING PROGRAM**

**IMMUNIZATION RECORD**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Required Immunizations for all Students:**

**MMR (Measles/Mumps/Rubella) OR Titer Result**

Dose 1: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_** Measles Titer: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

Month Day Year Month Day Year

Dose 2: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_** Mumps Titer: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

Month Day Year Month Day Year

Rubella Titer: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

Month Day Year

**Tdap (Tetanus, Diphtheria- within the last 8 years)**

Tdap or Td Booster (circle one)**: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

Month Day Year

**Varicella (Chicken Pox)**

Dose 1: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_** History of Disease: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

Month Day Year Month Day Year

Dose 2: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

Month Day Year

**Hepatitis B (3 Dose Series) OR Titer Result: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

Dose 1: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_** Month Day YearMonth Day Year

Dose 2: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

Month Day Year

Dose 3: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

Month Day Year

**TB Skin Test (Tuberculosis- 2 tests, 1 month apart)**

Test 1: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_** Negative\_\_\_\_ Positive\_\_\_\_

Month Day Year

Test 2: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_** Negative\_\_\_\_ Positive\_\_\_\_

Month Day Year

**Flu (Influenza- Yearly)**

1st Vaccine: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_** 2nd Vaccine: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

Month Day Year Month Day Year

**Recommended Immunizations:**

**Menactra (for Meningococcal Meningitis- 2 doses)**

Dose 1: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

Month Day Year

Dose 2: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

Month Day Year

**COVID (Current Booster)**

Product Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Received: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

Month Day Year

**Name of Clinic and/or Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Copies of vaccination records accepted in place of signature if accompanied by this form. \***