**STUDENT COMPLETION:**

**FULL NAME** (Last, First, MI):

**STUDENT ID**: **BIRTHDATE** (MM/DD/YY):

**PHONE / CELL**: **E-MAIL**:

**COMPLETION BY HEALTHCARE PROVIDER (PHYSICIAN OR NURSE PRACTITIONER ONLY):**

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| **IMMUNIZATIONS** |
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| **DPT**  \_\_\_\_\_\_\_\_\_\_\_\_ **TETANUS BOOSTER** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**see instructions)** **Tdap** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **(see instructions)**  **DATE DATE DATE** |
|  |  |
| **POLIO & M M R (MEASLES/RUBEOLA, MUMPS, RUBELLA/GERMAN MEASLES)** |
|  **1st MMR** **2nd** **MMR**  **POLIO \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_**  **DATE DATE (DATES OF ALL 4 INJECTIONS)****OR IF UNABLE TO VERIFY FOUR POLIO VACCINATIONS AND TWO** **MMR VACCINATIONS, YOU MUST PROVIDE TITER RESULTS.****TITER RESULTS****RUBELLA**   **IMMUNE NOT IMMUNE RUBEOLA** \_\_\_\_\_\_\_\_  **IMMUNE NOT IMMUNE**  **DATE DATE MUMPS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **IMMUNE NOT IMMUNE POLIO** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **IMMUNE NOT IMMUNE**   **DATE (Type 1, 2, & 3) DATE** **IF TITERS SHOW “No Immunity”, BEGIN THE IMMUNIZATION PROCESS IMMEDIATELY AND REPORT TO PROGRAM CLINICAL COORDINATOR.** |
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| **VARICELLA (CHICKEN POX)** |
|  **VARICELLA VACCINE**   **DATE**  **DATE** **OR IF UNABLE TO PROVIDE TWO DATES FOR VARICELLA VACCINE, YOU MUST PROVIDE TITER RESULTS.****TITER RESULTS** **VARICELLA**  **IMMUNE NOT IMMUNE** **DATE****IF NOT IMMUNE YOU MUST RECEIVE FIRST VARICELLA VACCINATION AND THE SECOND IN 4 WEEKS.** |
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| **HEPATITIS B (SERIES OF 3)** |
|  **1ST INJECTION**  **2ND INJECTION**  **3RD INJECTION**   **DATE (1 MONTH FROM 1ST) DATE (6 MONTHS FROM 1ST) DATE****OR IF UNABLE TO VERIFY HEPATITIS B INJECTIONS, YOU MUST PROVIDE TITER RESULTS.****TITER RESULTS** **HEPATITIS B**  **IMMUNE NOT IMMUNE** **DATE****OR** **HEPATITIS A** **HEPATITIS A VACCINE**   **DATE**  **OR IF UNABLE TO PROVIDE A DATE FOR HEPATITIS A VACCINE, YOU MUST PROVIDE TITER RESULTS.****TITER RESULTS** **HEPATITIS A**  **IMMUNE NOT IMMUNE** **DATE****IF NOT IMMUNE YOU MUST RECEIVE FIRST HEPATITIS A VACCINE IMMEDIATELY.**  |
| **INFLUENZA** |
|  **Annual Influenza Vaccination** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **DATE** |
|  |  |
| **IMMUNIZATION VERIFICATION** |
| **I verify the above named student’s immune status as listed.****PHYSICIAN or NURSE PRACTITIONER SIGNATURE DATE****ADDRESS OF PRACTICE CITY/STATE ZIP PHONE** |

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| **PPD TESTING(1ST PPD MUST BE WITHIN ONE YEAR OF 2ND PPD OR YOU WILL NEED TO COMPLETE “2-STEP”, PER INSTRUCTION SHEET)** |
|  **1st PPD**  **POSITIVE NEGATIVE Induration (mm) \_\_\_\_\_\_\_\_\_\_** **DATE PLACED DATE READ** **2nd PPD**  **POSITIVE NEGATIVE Induration (mm) \_\_\_\_\_\_\_\_\_\_** **DATE PLACED DATE READ****FOR POSITIVE RESULTS COMPLETE FOLLOW-UP INFORMATION BELOW.****CHEST X-RAY**  **DATE RESULTS** **INH? YES NO ANNUAL CHEST X-RAY RECOMMENDED? YES NO****I verify the above named student’s test results as listed.****PHYSICIAN/NURSE PRACTITIONER SIGNATURE DATE****ADDRESS OF PRACTICE CITY/STATE ZIP PHONE** |
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| **PHYSICAL EXAMINATION(MUST BE COMPLETED WITHIN 1 YEAR OF ADMISSION TO NURSING PROGRAM)** |
| The Department of Nursing Education seeks to provide as much as possible a safe environment for nursing students and their clients. Students are required to demonstrate physical and emotional fitness to meet the core performance standards of the nursing program. Such essential requirements include freedom from communicable disease, the ability to perform certain physical tasks, and suitable emotional fitness.**1. PHYSICAL EXAMINATION DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **2. BASED UPON YOUR EXAMINATION OF THE ABOVE NAMED INDIVIDUAL, WERE YOU ABLE TO IDENTIFY PHYSICAL LIMITATIONS THAT WOULD PREVENT THIS INDIVIDUAL FROM PARTICIPATING AS A NURSING STUDENT AT SHEPHERD UNIVERSITY? YES NO****IF YES, PLEASE EXPLAIN** **PHYSICIAN or NURSE PRACTITIONER SIGNATURE DATE****ADDRESS OF PRACTICE CITY/STATE ZIP PHONE** |

**FOR DEPARTMENT OF NURSING EDUCATION FACULTY USE ONLY**

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