Barry University
College of Nursing and Health Sciences
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IMMUNIZATION RECORD

To be completed by a licensed health care provider.

Student Name: _____

Date: ____/____/____ Date of Birth: ___/___/___ School ID # or Social Security # _____

THE FORM BELOW IS TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.
All information must be in English. A copy of the original immunization record(s) is preferred.
The immunizations listed below are **REQUIRED** for all students, prior to starting clinical rotations.

M.M.R. (Measles, Mumps, Rubella) Dose #1 ____/____/____ Dose #2 ___/___/___
(**Two doses required** at least 28 days apart for students born after 1956)
If given separately: ***OR***
Measles: Dose #1 ____/____/____ Dose #2 ____/____/____ OR Titer date and results ____/____/____ ☐ Immune ☐ Not Immune
Mumps: Dose #1 ____/____/____ Dose #2 ____/____/____ OR Titer date and results ____/____/____ ☐ Immune ☐ Not Immune
Rubella: Dose #1 ____/____/____ Dose #2 ____/____/____ OR Titer date and results ____/____/____ ☐ Immune ☐ Not Immune
*** ** (must provide a copy of lab results with numerical result) *****

TETANUS-DIPHTHERIA (Booster with Tdap ***OR*** Td within the last ten years **required**)
1. Booster: **Tdap** (**preferred**) to replace a single dose of Td for booster immunization at least 2-5 years since last dose of Td, depending on age of patient. (Administer with MCV4 simultaneously if possible)……___/____/____
2. Booster: **Td** within the last ten years……___/___/____

VARICELLA (either a history of chicken pox with a positive varicella antibody ***OR*** two doses of vaccine)
Varicella antibody date: _____/_____/_____ (*Please attach lab results*) Results: Immune Not Immune
Immunization: ……Dose #1 _____/_____/_____ Dose#2 _____/_____/_____

HEPATITIS B (Three doses of vaccine OR a positive Hepatitis B surface antibody OR complete attached waiver)
1. Immunization (Hepatitis B)
Dose #1 ____/____/____
Dose #2 ____/____/____
Dose #3 ____/____/____

OR

2. Hepatitis B surface antibody
Date ____/____/____
☐ Immune
☐ Not Immune

*** **(Must provide a copy of lab results with numerical result)*****

TUBERCULOSIS SCREENING
1. First PPD skin test Date given____/____/____ Date read _____/____/_____
Result :_____(Record actual mm of induration, if no induration, write "O")
2. Second PPD test Date given____/____/____ Date read _____/____/_____
Result :_____(Record actual mm of induration, if no induration, write "O")
3. Chest x-ray (**required if PPD skin test is positive**) *****required one time only - unless symptoms are present *****
Date of chest x-ray ____/____/____ Result: Normal ____ Abnormal ____
Symptom check list after first year Result: Normal ____ Abnormal ____

OTHER
Influenza vaccination Date given ____/_____/_____ *** (**must provide prescription**)***
Lot #_____ Expiration Date:_____

HEALTH CARE PROVIDER

(Please sign and place health care provider address and phone number or stamp below.)

Name: _____Signature: _____Date: _____

Address: _____ Phone: _____