COM - Nova Southeastern University Health Professions Division

Immunization Form

DO NOT MAIL records to your program office or admissions. Students must submit all immunization and physical forms to certifiedprofile.com by the deadline established by their college. Students should contact Certified Profile Student Services at (888) 914-7279 or email studentservices@certifiedprofile.com for questions.

Name (Print) _____ Date of Birth (M) ____ (D) ____ (Y) _____

College Program _____Phone # _____

TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER

REQUIRED: MEASLES, MUMPS AND RUBELLA VACCINE, or SEROLOGIC IMMUNITY to MEASLES and RUBELLA

MMR: Dose #1 (M)____ (D) ____ (Y) _____ Dose #2 (M)____ (D) ____ (Y) _____

or

Measles immunity: (M) ____ (D) ____ (Y) _____ **(lab result must be provided)**
Mumps immunity: (M) ____ (D) ____ (Y) _____ **(lab result must be provided)**
Rubella immunity: (M) ____ (D) ____ (Y) _____ **(lab result must be provided)**

Immune: (Yes)_____ No_____ (lab result must be provided)

Either (a) 2 doses of MMR vaccine or, (b) 2 doses of Measles, 2 doses of Mumps and 1 dose of Rubella, or (c) proof of immunity to Measles, Mumps, and/or Rubella.

REQUIRED: VARICELLA VACCINE or SEROLOGIC IMMUNITY
(Note: history of Chicken Pox is not acceptable)

Varicella vaccine: Dose #1: (M) _____ (D) _____ (Y) _____ Dose #2: (M) _____ (D) _____ (Y) _____

or

Varicella titer date: (M) ____ (D) ____ (Y) _____

Immune: (Yes)_____ (No) _____ (lab result must be provided)

If the titer is negative or equivocal, the student must provide evidence of 2 vaccines received in their lifetime.

REQUIRED: HEPATITIS B SERIES / HEPATITIS B TITER

Note: Your record will be considered INCOMPLETE until you have proof of serologic immunity as documented by a Hepatitis B Surface Antibody Titer. Please also note, you should only receive the Hepatitis B vaccine series one additional time if the first series did not result in immunity. After completion of the repeat three vaccines, you will need to have your titer redrawn after 60 days. If your lab results still do not show immunity you should consult your healthcare provider.

Hepatitis B Surface Antibody: (M)____ (D) ____ (Y) _____ Immune: (Yes)_____ (No) _____ **(lab result must be provided)**
*If your Hepatitis B Surface Antibody result shows immunity, you do not need to complete the three Hepatitis B vaccine series
*If your Hepatitis B Surface Antibody result shows you are not immune, you must have the three Hepatitis B vaccines and follow-up with Hepatitis B Surface Antibody titer 60 days after completing all 3 vaccines.

If needed

Hepatitis B: Dose #1: (M)____ (D) ____ (Y) ____ Dose #2: (M)____ (D) ____ (Y) ____ Dose #3: (M)____ (D) ____ (Y) ____

Follow-up titer after 60 days: (M)____ (D) ____ (Y) _____ (if needed)

REQUIRED: TETANUS-DIPHTHERIA – Tdap

Tetanus/Diphtheria/Pertussis (Tdap)** (M)____ (D) ____ (Y) ____

**Required. Due to the increased risk of pertussis in healthcare settings the Advisory Committee on Immunization Practices / CDC recommends "Healthcare personnel should receive a single dose of Tdap as soon as feasible if they have not previously received Tdap and regardless of the time since last Td dose." After receiving Tdap, routine booster shots against tetanus and diphtheria should follow existing guidelines every 10 years.

These immunization records will not expire

Valid for 10yrs

Mandatory Office or Healthcare Provider Stamp:

I certify that the information above is complete and accurate to the best of my knowledge:

Healthcare Provider Printed Name _____Date MM/DD/YR_____

Healthcare Provider Signature _____ Office Phone # _____

Office Address _____

Nova Southeastern University Health Professions Division

Immunization Form Continued

PPD/Tuberculosis Screening

(Must be completed within 12 months prior to entering the program)

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Name (Print) _____ Date of Birth (M)____ (D) ____ (Y) _____

College Program _____Year entering program _____

TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER

****Quantiferon Tuberculosis Testing can be done in lieu of PPD****

A documented negative Quantiferon - TB Gold within 12 months prior to start of program will substitute for two-step PPD screening below. Quantiferon - TB Gold _____ (results attached)

The renewal date will be set for one year from latest PPD or two years from latest chest X-ray

REQUIRED: 1st step PPD/Tuberculosis Screening

Step one:

PPD applied: (M) ____ (D) ____ (Y) _____ By: _____

PPD read: (M) ____ (D) ____ (Y) _____ By: _____

Results _____ (mm)

Positive_____ Negative_____ (if Step One is negative, proceed to Step Two, 7 days and no longer than 12 months from step one PPD.)

If positive, you must attach a chest x-ray report and will not be required to proceed to step two

Prophylactic treatment for positive PPD: Yes_____ No _____

Treated with: _____ x _____ (months)

Completed treatment date: (M)____ (D) ____ (Y) ____

REQUIRED: 2nd step PPD/Tuberculosis screening (must be at least 7 days and no longer than 12 months from step one PPD)

Step two:

PPD applied: (M) ____ (M) ____ (Y) ____ By: _____

PPD read: (M) ____ (D) ____ (Y) ____ By: _____

Results _____ (mm)

Positive_____ Negative_____ (if Step One is negative, proceed to Step Two 1-3 weeks after step one.)

If positive, you must attach a chest x-ray report

Prophylactic treatment for positive PPD: Yes____ No____

Treated with: _____ x _____ (months)

Completed treatment date: (M) ____ (D) ____ (Y) ____

I certify that the information above is complete and accurate to the best of my knowledge:

Healthcare Provider Printed Name _____ Date MM/DD/YR_____

Healthcare Provider Signature _____ Office Phone #_____

Office Address_____

Mandatory Office or Healthcare Provider Stamp:

Nova Southeastern University Health Professions Division

Certificate of Physical Examination

Based on review of the patient's medical history, immunization records, and physical examination performed and on file in my office this date_____, it is my impression that

Name of student_____

Social Security Number_____

College Program_____

Date of Birth_____

has received the required immunizations and that he/she meets the physical requirements for attendance at Nova Southeastern University Health Professions Division.

I certify that the information herein is complete and accurate to be best of my knowledge.

Healthcare Provider Printed Name_____

Healthcare Provider Signature_____ Date_____

MANDATORY Office or Healthcare Provider Stamp:

Office Phone Number_____

Office Address _____

_____

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