GEORGIA SOUTHERN UNIVERSITY
SCHOOL OF NURSING
IMMUNIZATION FORM

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<tr>
<th>Student Name</th>
<th>Date of Birth</th>
<th>Eagle ID #</th>
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**School of Nursing Required Immunizations or Tests:**
(Must be completed prior to enrollment in the first nursing course)

**A. TB Test: Quantiferon TB or Gold In-Tube (QFT-GIT) or the PPD 2 step method (need 2 separate PPD test done)**

Date:_______ Provider:_________ Result:_________

1st Step Date________ Read Date________ Result:_________

2nd Step Date________ Read Date________ Result:_________

Evidence of x-ray or follow-up/prophylaxis if PPD is positive* Date:____________ Result:____________

*Attach summary from health care provider regarding follow-up of any positive PPD.

**B. Hepatitis B**

Dose #1 Date:_________ Provider Initials________ Agency_____________________

Dose #2 Date:_________ Provider Initials________ Agency_____________________

Dose #3 Date:_________ Provider Initials________ Agency_____________________

or Immune titer Date:_________ Result:____________

or Vaccine refusal Date:_________ Attach Form

Waiver form for incomplete series Date:_________ Attach Form

**C. MMR (Measles, Mumps, Rubella)** if born after 1957, or laboratory evidence of immunity (specify date of titer and attach test results). If Vaccinations completed at age appropriate no titer is recommended by the CDC

Dose 1 - immunized at 12 months of age or later Date:____________

Dose 2 - immunized at least 30 days after Dose 1 Date:____________

**D. Tdap (Tetanus, Diphtheria and Pertussis)** Required unless evidence* of receiving a Tdap at age 11 or older (Attach GRITS or other form)

**E. Seasonal Flu Vaccine**--- Need Electronic Form with Provider Signature Date:____________

**F. Varicella**

_____ I have had a Varicella Titer: Date _______________ Result:________________

OR I have been immunized against Chicken Pox. Varicella vaccine X2 doses: Date 1st dose:_______________

Date 2nd dose:_________ If Vaccinations completed at age appropriate no titer is recommended by the CDC

Print or type name and address of health care provider completing this form.

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<th>Name</th>
<th>Address</th>
<th>Title</th>
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<th>City or Town</th>
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Immunization status above is certified by:

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<th>Signature of Health Care Provider</th>
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