

Addendum B
St. David's School of Nursing – Texas State University Immunizations and Tests Form

Student Name: _____ **TXST ID: A0** _____ **Date of Birth:** _____

Attention Healthcare Provider: *Students must provide documentation of immunization history or have received the required tests or immunizations prior to admission to the nursing program.*

MEASLES/MUMPS/RUBELLA OR MMRV* VACCINE – one of the following is required:

Two doses of the MMR vaccine. Must be a minimum of 28 days between doses.

Date #1 (mm/dd/yy): _____ Date #2 (mm/dd/yy): _____

OR

Two doses of the MMRV vaccine. Must be a minimum of 90 days between doses.

Administration Date #1 (mm/dd/yy): _____ Administration Date #2 (mm/dd/yy): _____

OR

Measles/Mumps/Rubella Serologic titer. Must show positive antibodies.

Date of test (mm/dd/yy): _____ Circle Results: Positive Negative

****Those who chose the MMRV do not need a separate Varicella immunization. You DO need a serologic titer if you have not been vaccinated.***

VARICELLA (Chicken Pox) – one of the following is required: *(History of Chicken Pox does not meet requirement.)*

Two Varicella vaccines administered at least 4 – 8 weeks apart.

Administration Date #1 (mm/dd/yy): _____ Administration Date #2 (mm/dd/yy): _____

OR

Varicella Serologic titer. Must show positive antibodies.

Date of test (mm/dd/yy): _____ Circle Results: Positive Negative

Tdap: Tdap protects against Tetanus, Diphtheria, and Pertussis. This vaccine is to be given every ten years.

Note: Tetanus (Td) is NOT acceptable.

Administration Date (mm/dd/yy): _____

Note: It is the student's responsibility to schedule the Tdap vaccine if it expires while in nursing school. Additional renewals of the Tdap immunization should be uploaded into your Clinical Student account under the BSN/MSN Tetanus (Tdap) Vaccination.

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MENINGOCOCCAL VACCINE: Evidence of vaccination is required if a student is 21 years old or younger on the first day of the fall semester. Also submit proof of this vaccine to Texas State University.

Administration Date of vaccine (mm/dd/yy): _____

Note: *For students who are 22 years and older, the Meningococcal vaccine is not required by the St. David's School of Nursing but is recommended. Rationale: During clinical rotations in hospitals and community centers you will be exposed to a wide variety of patients including those who have Meningitis.*

HEPATITIS B (HEP B) Surface Antibody (titer)— draw titer to document immunity. This should be drawn no sooner than 1-2 months after last Hep B dose received. And the titer must be drawn within 12 months of admission into the nursing program. *Titer results must be quantitative with reference ranges included in the results.*

Date titer drawn (mm/dd/yy): _____ Circle Results: Positive Negative

A titer showing non-immunity (non-reactive, negative) will require one of the below series of Hepatitis B vaccine and a repeat titer 1-2 months after the last dose of the vaccine. *The results must be quantitative with reference ranges included.*

****If additional doses are required to obtain immunity, document the doses and dates received below:***

HEPATITIS B (HEP B) Series:

The 3-dose series (Engerix-B or Recombivax HB) of the vaccine administered over a period of at least 6 months (schedule of 0,1,6 months). Initial vaccine is followed by the 2nd dose in 1-month and the third dose is 5 months after the 2nd dose. Note: The third vaccine must be at least 6 months from initial vaccine.

Dose #1 Administration Date (mm/dd/yy): _____

Dose #2 Administration Date (mm/dd/yy): _____

Dose #3 Administration Date (mm/dd/yy): _____

OR

The 2-dose series (Heplisav-B) of the vaccine requires a minimum of 4 weeks between doses. The administration record must clearly identify the Heplisav-B series was given.

Heplisav-B Dose #1 Administration Date (mm/dd/yy): _____

Heplisav-B Dose #2 Administration Date (mm/dd/yy): _____

It is the student's responsibility to schedule necessary vaccination titers or the necessary boosters/challenges.
Upload documentation of this additional information into your Clinical Student account.

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TUBERCULOSIS (TB) TESTING: Must be completed between stated deadlines in Clinical Student.

Students must receive the **T-Spot** or **QuantiFERon** TB Blood Test and submit results.

Date of test (mm/dd/yy): _____ Circle Results: Positive Negative

If a student tests positive for TB, include a synopsis of their treatment plan with this form. If appropriate, the following are minimum requirements to be included in this plan:

- Blood test (T-Spot or QuantiFERon) if prior positive blood test
- Blood test (T-Spot or QuantiFERon) if prior BCG vaccination
- Chest X-ray within the past two years
- Current completed Tuberculosis Assessment and Symptoms Checklist. Attach the completed checklist (with student's name and DOB to this form).

Treatment plan:

This document must be signed by the healthcare provider (MD, DO, PA, or APRN).

Healthcare provider's printed name: _____

Healthcare Facility Name (address/city/state/zip): _____

Signature of healthcare provider: _____ Date: _____

****Your signature on this form indicates you have validated the evidence of the required immunizations or tests for this student. STAMPS ARE NOT ACCEPTED.***

Students: After your healthcare provider completes this Immunizations and Tests Form including his/her signature, upload the completed form and your completed Health Certificate onto your Clinical Student account.

Revised 06/2023 Director's Council