

2025 -2026 St. David's School of Nursing – Texas State University Immunizations and Tests (I&T) 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.

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

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

OR

Varicella Serologic titer. Must show positive antibodies.

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

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

Note: 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 compliance documentation 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. Submit proof of this vaccine to your clinical compliance documentation account.

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. 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

Nonimmunity: A titer showing non-immunity (non-reactive, negative) will require one of the below series of Hepatitis B and a repeat titer 1-2 months after the last doses of 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 ONE month, with the 3rd dose given FIVE months after the 2nd dose. **Note: Third vaccine must be at least 6 months from initial vaccine.**

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

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

Dose #3 - Date #3 (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 - Date #1 (mm/dd/yy): _____

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HepB-Dose #2 – Date #2 (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 compliance documentation third-party vendor (e.g., Clinical Student™) account.

TUBERCULOSIS (TB) TESTING: Must be completed within 12 months of the start of the program.

Students must receive an interferon-gamma release assay (IGRA) T-SPOT®.TB test (T-Spot) QuantiFERON®-TB Gold Plus (QFT-Plus) blood test.

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. 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 results from within the past two years
- Current, completed SON Tuberculosis Assessment and Symptoms Checklist and/or County/Health Department Risk Assessment Form with provider statement of student infectious risk and safety to work with patients. Attach the completed checklist (with student's name and DOB to this form).
- Provider's detailed treatment plan.

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 I&T Form including signature, upload this completed form **and** your completed Health Certificate onto your clinical compliance documentation account through the third-party vendor (e.g., Clinical Student™). 3