

## Moravian College Helen S. Breidegan School of Nursing Immunization Form

<b>Last Name:</b>		<b>First Name:</b>		<b>Middle Initial:</b>	
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**MMR (Measles, Mumps, Rubella) – 2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and (1) dose of Rubella; or serologic proof of immunity for Measles, Mumps and/or Rubella**

Option 1	Vaccine	Date	
<b>MMR</b> -2 doses of MMR vaccine	MMR Dose #1	_/_/___	
	MMR Dose #2	_/_/___	
Option 2	Vaccine or Test	Date	
<b>Measles</b> - 2 doses of vaccine or positive serology	Measles Vaccine Dose #1	_/_/___	
	Measles Vaccine Dose #2	_/_/___	
	Serologic Immunity (IgG, antibodies, titer)	_/_/___	<input type="checkbox"/> Copy Attached
<b>Mumps</b>	Mumps Vaccine Dose #1	_/_/___	
	Mumps Vaccine Dose #2	_/_/___	
	Serologic Immunity (IgG, antibodies, titer)	_/_/___	<input type="checkbox"/> Copy Attached
<b>Rubella</b> - 1 dose of vaccine or positive serology	Rubella Vaccine	_/_/___	
	Serologic Immunity (IgG, antibodies, titer)	_/_/___	<input type="checkbox"/> Copy Attached

**Varicella (Chicken Pox)- 2 doses of vaccine or positive serology**

	Varicella Vaccine #1	_/_/___	
	Varicella Vaccine #2	_/_/___	
	Serologic Immunity (IgG, antibodies, titer)	_/_/___	<input type="checkbox"/> Copy Attached

**Hepatitis B Vaccination— 3 doses of vaccine followed by a QUANTITATIVE Hepatitis B Surface Antibody (titer) preferably drawn 4-8 weeks after 3<sup>rd</sup> dose. If negative, complete a second Hepatitis B series followed by a repeat titer. If Hepatitis B Surface Antibody is negative after a secondary series, additional testing including Hepatitis B Surface Antigen should be performed. See: <http://www.cdc.gov/mmwr/pdf/rr/rr6103.pdf> for more information.**

*Documentation of Chronic Active Hepatitis B is for rotation assignments and counseling purposes only.*

<b>Primary Hepatitis B Series</b>	Hepatitis B Vaccine Dose #1	_/_/___	
	Hepatitis B Vaccine Dose #2	_/_/___	
	Hepatitis B Vaccine Dose #3	_/_/___	
	<b>QUANTITATIVE</b> Hep B Surface Antibody	_/_/___	Result: _____ mIU/ML <input type="checkbox"/> Copy Attached

<b>Secondary Hepatitis B Series</b>  (If no response to primary series)	Hepatitis B Vaccine Dose #4	__/__/__	
	Hepatitis B Vaccine Dose #5	__/__/__	
	Hepatitis B Vaccine Dose #6	__/__/__	
	<b>QUANTITATIVE</b> Hep B Surface Antibody	__/__/__	Result: ____ mIU/ML <input type="checkbox"/> Copy Attached
<b>Chronic Active Hepatitis B</b>	Hepatitis B Surface Antigen	__/__/__	<input type="checkbox"/> Copy Attached
	Hepatitis B Viral Load	__/__/__	<input type="checkbox"/> Copy Attached
<b>Tetanus-diphtheria-pertussis-</b> <i>One(1) dose of adult Tdap. If last Tdap is more than 10 years old, provide date of last Td and Tdap</i>			
	Tdap Vaccine (Adacel, Boostrix, etc)	__/__/__	
	Td Vaccine (if more than 10 years since last Tdap)	__/__/__	

**TUBERCULOSIS SCREENING-** *Results of last (2) TSTs (PPDs) or (1) IGRA blood test are required **regardless** of prior BCG status. If you have a history of a positive TST (PPD)≥10mm or IGRA please supply information regarding any evaluation and/or treatment below. You only need to complete ONE section.*

**Skin test should be good for 1 year**

**Or**

**Must be updated with the receiving institution prior to rotation.**