AUGUSTANA UNIVERSITY

Augustana University Nursing Program Required Immunization Form	**STUDENT NAME:**
	DATE OF BIRTH:

This form consists of required immunizations and must be completed and verified by a healthcare provider (Physician, PA, NP, Nurse). Please take note of additional official documentation that may be required for some vaccines below.

A. MMR (Measles, Mumps, Rubella) Vaccine:
Two doses required

1. _____/_____/_____
2. _____/_____/_____

B. TDaP (Tetanus, Diphtheria, Adult Pertussis):
One adult Tdap required

1. _____/_____/_____

C. Varicella (Chicken Pox)
Positive Titer or two doses of vaccine are required
Vaccine Dates

1. _____/_____/_____
2. _____/_____/_____

OR Documentation of Positive Varicella Titer:
Attach a copy of the titer report – if titer is negative, varicella vaccine required

1. _____/_____/_____

D. Hepatitis B Vaccine:
Three doses and positive titer required

1. _____/_____/_____
2. _____/_____/_____ (1 month after 1st dose)
3. _____/_____/_____(6 months after 1st dose)

AND Hepatitis B Titer – attach copy of titer report

1. _____/_____/_____
Positive/Reactive_____
Negative/Nonreactive* _____ (booster/repeat series)
*If titer is negative student must receive a booster/repeat series. Date of booster:
_____/_____/_____

E. COVID Vaccination: Require two doses of Pfizer or Moderna or one dose of Janssen Vaccine.
Attach a copy of your vaccination card or your electronic medical record showing your name, date or birth and date(s) of vaccination.

F. Tuberculosis: Skin Test – PPD (Mantoux) **or Blood Test**– ****TB Test must be updated annually**

☐ Two-Step TB Skin Test; recommended 1-3 weeks apart. **If students have drawn TB annually, may supply last year's reading as step 1 and the current year's reading as step 2.*

Step 1 (Date placed) _____/_____/_____ - Date read _____/_____/_____ Results: _____mm
Step 2 (Date placed) _____/_____/_____ - Date read _____/_____/_____ Results: _____mm

OR

☐ Tuberculosis Blood Test: Date _____/_____/_____ Positive_____ Negative_____
Attach copy of report

☐ History of Positive TB Skin Test: Date: _____/_____/_____
Documentation of chest x-ray & treatment required

G. Influenza vaccine: Required annually (Fall exchange students will do in US, Spring exchange please submit)

Provider Signature:	**Date: _____/_____/_____**
Print Provider Name:	**Hospital/Clinic:**