Augustana University – Department of Nursing
REQUIRED IMMUNIZATION FORM

Name: ______________________________ **Date of Birth:** ____________________**Augustana ID :**________________

Name of Emergency Contact: _______________________________ **Phone:** __________________________________

REQUIRED IMMUNIZATIONS:

A. MMR (Measles, Mumps, Rubella) Vaccine. Two doses required for all students
Dates: 1. ____/_____/______ 2. _____/_____/______

B. TDaP (tetanus, diphtheria, adult pertussis): One adult TDaP
Date: _____/_____/______

C. Varicella (Chicken Pox) One of the following is required:
☐ Documentation of positive varicella titer. Date: _____/_____/______ attach copy of titer report
(if negative, varicella immunization required)
OR
☐ Vaccine: Two doses are required for those without evidence of immunity.
Dates: 1. _____/_____/______ 2. _____/_____/______

D. Hepatitis B Vaccine – Three doses and positive titer required.
☐ 1st dose – Date: _____/_____/______
☐ 2nd dose – Date: _____/_____/______ (1 month after 1st dose)
☐ 3rd dose – Date: _____/_____/______ (6 months after 1st dose)
AND
☐ **Immunity demonstrated by Hepatitis B Titer** – *attach copy of titer report*
Date: _____/_____/______ Positive/Reactive _____ Negative/Nonreactive_____ (booster/repeat series)
*If titer is negative student must receive a booster/repeat series. Date started (if needed): _____/_____/______

E. COVID-19 Vaccination
☐ **Pfizer or Moderna Vaccine**
Dates: 1. _____/_____/______ 2. _____/_____/______
OR
☐ **Janssen Vaccine**: Date: _____/_____/______

F. Tuberculosis Skin Test – PPD (Mantoux) – ****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
☐ QuantiFERON-TB Gold Blood Test (QFT-G): 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 - Date: _____/_____/______

SIGNATURE ____ **DATE: _____/_____/______**
Must be signed by Healthcare Provider (Physician, PA, NP, Nurse)

PRINT NAME _____________________________________ **HOSPITAL/CLINIC** ___________________________________