

Student Name				
Last	First	Middle	Phone Nu	ımber
Permanent Address Street Number/N	ame	City	State	Zip Code
Date of Birth Mo Day Yr PF	PCC S#	Student Em	ail:	*
PART A: <u>TO BE COMPI</u> <u>PROVIDER.</u> You may als	o attach any off			
example your flu shot rece 1. <u>TETANUS, DIPHTHERIA & PEI</u>	-	er must be within the last	ten years Mo Day	Yr
II. <u>MMR (Measles, Mumps, Rubella</u> <u>Two doses</u> required, at leas		ose #1 Mo Day Yr	Dose #2 Mo Day	Yr
Students in postsecondary edu immunocompromised persons received 1 dose MMR, or 2-d	s with no evidence of in ose series MMR at least	munity to measles, mump 4 weeks apart if previous	os or rubella: 1 dose MN	AR if previously
OR ALL 3 OF THE FOLL(MEASLES (RUBEOLA) Has report of positive immu			ue of Titer:	
Or <u>two doses</u> of indi	vidual rubeola vaccine:	Dose #1	Dose #2	
<u>RUBELLA (GERMAN MI</u> Has report of positive immu		Mo Day Yr	of Titer:	
Or <u>two doses</u> of indi	vidual rubella vaccine:	Dose #1 Mo Day Yr	Dose #2 Mo Day 1	ír
MUMPS Has report of positive immu	une <u>titer</u> . Specify date:	Mo Day Yr	of Titer:	
Or <u>two doses</u> of indi	vidual mumps vaccine:	Dose #1 Mo Day Yr	Dose #2 Mo Day Y	r

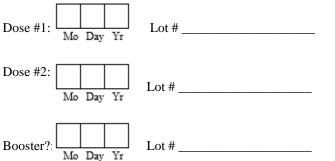
Healthcare personnel born in 1957 or later with no evidence of immunity to measles, mumps or rubella: 2-dose series MMR at least 4 weeks apart for measles or mumps, or at least 1 dose MMR for rubella; if born before 1957, consider 2-dose series MMR at least 4 weeks apart for measles or mumps, or 1 dose MMR for rubella

PART B: Hepatitis B, Varicella, Tuberculosis Screening

III. HEPATITIS B:					
Has report of positive immune <u>titer</u> . Specify date: Value of Titer:					
Mo Day Yr Or <u>three doses</u> of individual hepatitis vaccine:					
Dose #1 Dose # 2 Dose #3 Dose #3					
Mo Day Yr Mo Day Yr Mo Day Yr					
IV. <u>VARICELLA</u> : (chicken pox): Two doses one month apart recommended for adults with r	no history of disease:				
Has report of positive immune <u>titer</u> . Specify date: Value of Tites (History of disease cannot be accepted) Mo Day Yr	r:				
Or two doses of individual varicella vaccine: Dose #1 Dose #2 Dose #2	Mo Day Yr				
V. <u>TUBERCULOSIS</u> :					
1. Does the student have signs or symptoms of active TB disease? YE If NO, proceed to 2.	S no				
If YES, proceed with additional evaluation to exclude active TB disease incl x-ray and sputum evaluation as indicated.	uding tuberculin skin testing, chest				
PLEASE USE THE SPACE BELOW TO DOCUMENT TUBERCULIN SKIN TESTING RADIOGRAPHY (Based on assessment criteria outlined above)	G AND/OR CHEST				
2.A. <u>Tuberculin Skin Test/PPD</u> :					
Date given: Date read: Results:	ММ				
	ons, transverse diameter, if no in duration, write "0")				
Positive Negative					
B. <u>Chest X-Ray</u> : (required if tuberculin skin test is positive or if PPD has not been plac	ed but patient is at risk of disease;				
must have been performed.					
Result: Image: Description of the sector of the s					
INH Initiated DateXmonths					
C. <u>Quantiferon:</u> Date of Test: Positive $(\geq 0.35 \text{ IU/mL})$ Neg					
History of positive PPD and/or negative Quantiferon results requires <u>annual TB screening</u> v					
1. Have you been having a bad cough that last longer than 2 weeks?	⊔ YES ⊔ NO				
2. Have you been having pain in the chest?					
3. Have you been coughing up blood or sputum (phlegm from deep inside the lungs)?					
4. Have you experienced weakness or fatigue?	U YES U NO				
5. Have you experienced chills, fevers, or sweating at night?	∐ YES ∐ NO				
6. Have you experienced weight loss or a loss of appetite?	☐ YES ☐ NO				
CONTINUE on to Part C for Influenza Vaccine (Required for all students)					

PART C. Influenza

VI. <u>INFLUENZA</u> :			
Date of last dose: Mo Day Yr	Lot #	Location given:	
PART D. COVID 19			
VI. <u>COVID</u> : Brand of Vaccine			



*Is general health adequate to allow participation in a nursing education program and to perform essential duties of an RN working in a hospital or clinic, including CPR, administration of IV medication, opening of obstructed airways, catheterization, safe patient transfer/lifting, and other motor skills?

YES _____ NO _____

HEALTH CARE PROVIDER: (signature required as validation of correct information for immunizations and TB assessment)

Printed Name:	Address:		
		Street Number/Name	
Signature:	City	State	Zip Code
Date:	Phone:		

I ______(student) give consent for PPCC Nursing Program to share the results of the immunizations and physical questionnaire with clinical agencies as requested

Student Signature

Date