Records of baseline MMR vaccines (or titers) are collected and are on file for all entering University of Saint Joseph students who are not date of birth exempt (as follows). Any student previously exempted based on date of birth prior to 1957 must now submit records for the two vaccine MMR requirements (or equivalent) to meet the requirements of host health care facilities.

**TETANUS/ DIPHTHERIA/ PERTUSSIS**

Booster date ________________ (Please circle: Td Tdap)

A tetanus booster should be given every 10 years. Health care workers younger than age 65 years who have not previously been provided with a booster dose of Tdap as soon as it is feasible.

**VARICELLA (CHICKEN POX)** Please document immunity below:

- □ 2 doses of varicella vaccine ≥ 28 days apart
  - Dose # 1 ________________
  - Dose # 2 ________________

OR → □ Titer results attached

If titers show student is not immune, additional immunizations as noted are necessary. Please note that students who claimed immunity by natural disease when entering the University of Saint Joseph must now obtain a titer to meet the requirements of host health care facilities.

**HEPATITIS B SERIES**

Administered per standard schedule

- Dose # 1
- Dose # 2
- Dose # 3

OR →

Hepatitis B Surface Antibody Titer Immune? Yes______ No______ □ Titer results attached

Non-immune individuals should be offered re-vaccination according to standard protocols. Students who wish to decline vaccination or re-vaccination should be advised of risk and will be asked to sign a declination form in the campus Health Services office. A titer is not required but is recommended for those now receiving the vaccine series.

**Color blindness screen** (one time requirement undergraduates)

Date ________________

Result ____________________

12/11 Primary Care Providers and students- please be sure to complete both sides of form. Completed forms may be faxed to 860.231.6794.
Primary Care Provider: Please provide an evaluation of this student’s ability to perform routine activities and duties of a nurse or nurse practitioner.

Latex Allergy  yes  no  Communicable disease  yes  no  
Back/neck condition or injury  yes  no  Other musculoskeletal condition(s)  yes  no  
Other medical condition(s)  yes  no  Please specify condition(s)____________________

☐ Student may practice in an environment where latex is present.

☐ Based on my examination this student can participate fully in nursing clinical rotations without restrictions or limitations.

☐ Based on my examination this student can participate in clinical rotations but the following modifications are necessary:
________________________________________________________________________________________
________________________________________________________________________________________

MD/APRN/PAC signature _________________________________  Date of exam ______________________

Printed provider name _________________________________  *** Or affix office stamp below ***

Address __________________________________________

Telephone _________________________________________

Fax_______________________________________________

Annual Updates

Annual tuberculosis screening is required to meet needs of host health care facilities. Individuals testing positive on the PPD test are required to submit additional records if not submitted at the time of enrollment. These are (one or more of the following: report of chest x-ray at time of diagnosis, results of an IGRA blood test such as Quantiferon Gold® or Tb Spot® test and past treatment records. PPD positive individual must also complete a brief symptom/risk inventory on campus on an annual basis.

PPD:  Date given ____________  Date read ________  Results__________  Influenza vaccine:  Date given

Student Section

I ________________________ (student name) authorize the release of a copy of my health records when required by clinical agencies. I also herein grant permission to Health Services staff to release my private health information to the assigned faculty member or Clinical Coordinator for the express purpose of determining my ability to participate in clinical rotations.

_____ I understand it is my responsibility to promptly report changes in my health status, including injuries sustained at a clinical site. Participate in clinical rotations. Injuries and health status changes affecting my ability to perform routine clinical activities should be reported to both my assigned clinical faculty member and the campus Health Services staff.

_____ [Graduate students only] I authorize the designated individual(s) to maintain a copy of this form and attached records in a secure location within the Nursing Division’s offices during the duration of my attendance at the University of Saint Joseph. Upon graduation these records will be destroyed by shredding.

Student signature _________________________________  Date ______________________