**York College Nursing Student Immunization Form**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To be completed and stamped by a physician.

I hereby certify that I have examined and performed a physical on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**York College Medical Record form must be attached**).

And I have concluded that he/she appears to have the physical and mental capabilities to function in the capacity required. It appears, in addition, that he/she is free from a health impairment which is of potential risk to patients or which might interfere with the performance of hrs/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter the individual’s behavior.

1. Medical History and Physical Examination (**within 4 months of semester start date**) Findings:
* Normal
* Abnormal Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. Rubella titer on: \_\_\_\_\_\_\_\_\_\_ OR Rubella vaccination Date:
* Immune \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Non-immune
1. Rubeola Titer on:\_\_\_\_\_\_\_\_\_\_\_ OR MMR:
* Immune #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Non-immune #2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. Varicella Zoster titer on\_\_\_\_\_\_\_ OR Varicella vaccination dates:
* Immune #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Non-immune #2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. Mumps titer on\_\_\_\_\_\_\_\_\_\_\_\_\_ OR Mumps vaccination dates:
* Immune #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Non-immune #2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. Hepatitis B surface antibody titer on\_\_\_\_\_\_\_ OR Hepatitis B vaccination dates:
* Immune #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Non-immune #2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* #3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. Tetanus Vaccine (every 10 years) Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Report on TB testing (Within 3 Months of start date, measured in mms)
* PPD test on\_\_\_\_\_\_\_\_\_\_\_\_\_ Negative\_\_\_\_\_\_\_\_\_ Positive\_\_\_\_\_\_\_\_\_\_\_\_
* Chest X-ray on\_\_\_\_\_\_\_\_\_\_ Negative\_\_\_\_\_\_\_\_\_ Positive \_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*MANDATORY: Attach copy of titer results or proof of vaccinations to this form and all supporting documents signed and stamped by physicians.**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised June 2012; July 2020