CUA

THE CATHOLIC UNIVERSITY OF AMERICA

School of Nursing

Washington, DC 20064

202-319-5400

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IMMUNIZATION VERIFICATION FORM

Immunization History (Student Name: ______________________)
Last First

Please fill in dates given (Month, Date, and Year) (xx-xx-xxxx)

Polio: Date original series completed or reimmunized: ___________
(REQUIRED for all Nursing students)

T d + Pertussis ___________

Tetanus: Last booster (Must be within 10 years) ___________

MMR (Measles, Mumps, Rubella) 1st Dose___________ 2nd Dose____________
(Two doses required before 1st birthday)

OR **MMR Titers** **Measles** ___________ **Mumps**___________ **Rubella** ___________
(Must attach lab results)

Hepatitis B: (series of 3 injections) 1st Dose____________ 2nd Dose____________ 3rd Dose____________

Or **HBsAB** (titer) _________________
(Must attach lab results)

Varicella (Chicken Pox) must have vaccines or titer

Varicella Vaccine 1st Dose ________ 2nd Dose__________

Or **Varicella Titer** __________
(Must attach lab results)

If student had Chicken Pox, student must have Varicella titer.

(Must attach lab results to show immunity) If history of disease, MUST have immune titer

Primary Care Provider Name/Credentials: ____ (PRINT)

Primary Care Provider Signature: ____

Primary Care Provider Address: ____

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Telephone: ________________________________