Institute for Accelerated RN Success, Inc.

Immunization Record Form

FORM INSTRUCTIONS

- **FORM SUBMISSION DEADLINES: Prior to Student Registration**
- ALL students must complete and sign/initial Parts 1, 2, 3 & 4. If student is under 18 years of age, Part 2a must be completed.
- ALL students born after 12/31/1956 must provide proof of immunizations listed in Part 6. Part 6 must be completed and signed by a healthcare provider.
- This form, along with any applicable outside records, must be submitted by the deadline. Records that are late or incomplete will be assessed a hold will be placed on the student's Web account, this will prevent class registration for the following term. Please write R# on all pages that are being submitted.
- Submit forms via mail, email, fax, or in person to the Ocala office.
- All records must be in English.

PART 1. PERSONAL INFORMATION -- TO BE COMPLETED BY ALL STUDENTS, PRINT LEGIBLY		
Last Name	First Name	Student G#
U.S. Address		
City	State	Zip Code
Date of Birth	Home Phone	Cell Phone

PART 2. EMERGENCY CONTACT INFORMATION -- TO BE COMPLETED BY ALL STUDENTS

In the event of an emergency, I give Student Services permission to contact: Student initials for permission to contact _____

Name	Home Phone	Cell Phone

PART 2a. MINOR CONSENT -- ONLY IF STUDENT IS UNDER 18 YEARS AT TIME OF ENROLLMENT

Parental permission or the consent of a legal guardian must be obtained to provide medical or surgical care to minors. To avoid delays in treatment in the event of illness or accident, please obtain the signature of a parent/legal guardian if you are under 18 years of age at the time of enrollment.

I hereby authorize the staff of this Institute to assess and if necessary treat my minor/dependent or transport to nearest healthcare facility as deemed advisable.

Parent/Guardian Signature_____ Date_____

Printed Name of Parent/Guardian Relationship

PART 3. DISCLAIMER -- TO BE COMPLETED BY ALL STUDENTS

Student Admission Services reserves the right to request supporting documentation of your immunization records and request titers and/or vaccinations at your expense.

Student Signature (physical)_____ Date _____

Student Name _____ R # _____

PART 4. TUBERCULOSIS SCREENING -- TO BE COMPLETED BY ALL STUDENTS AND/OR HEALTHCARE PROVIDER

The following tuberculosis (TB) screening questions are required for <u>all</u> students. Refer to below list of countries for Questions 1 and 2.

Select Yes or No

1. Were you born in a country where tuberculosis is endemic **<u>AND</u>** will arrive or have arrived in the U.S. within the last five (5) years? ☐ Yes ☐ No

Date Arrived or Intended Date to Arrive in U.S. _____ Country of birth _____

2. **Within the last five (5) years** have you traveled for **three (3) consecutive months** or more to countries where tuberculosis is endemic? ☐ Yes ☐ No

Date(s) of Travel last 5 years _____ Length of Stay _____

Country(ies) list _____

3. Have you had close contact with anyone who is or was sick with tuberculosis? ☐ Yes ☐ No

4. Have you ever tested positive for tuberculosis? ☐ Yes ☐ No

If yes, please provide documentation of history with chest x-ray report.

5. Do you have any medical conditions such as chronic renal failure, leukemia, or lymphoma, HIV infection or any other immunosuppressive disorder? ☐ Yes ☐ No

6. Do you have any symptoms of active tuberculosis, such as: cough >3 weeks, night sweats, fever, unexplained weight loss and/or fatigue? ☐ Yes ☐ No

7. Have you resided in, volunteered or worked in a high-risk congregate setting such as prisons, nursing homes, hospitals or homeless shelters? ☐ Yes ☐ No

Initials of student or healthcare provider _____

If answers to <u>ALL</u> the above questions are **NO**, <u>no</u> TB testing or chest x-ray is required; go to Part 6.

If the answer is <u>YES</u> to <u>ANY</u> of the above questions, the Institute requires your healthcare provider to **complete Part 5** on the next page (tuberculosis test).

List of Countries for Questions 1 and 2 (WHO reference 2016-2020)

Angola	Indonesia	Peru
Azerbaijan	Kazakhstan	Philippines
Bangladesh	Kenya	Russian Federation
Belarus	Korea, Democratic People's	Sierra Leone
Botswana	Republic	Somalia
Brazil	Kyrgyzstan	South Africa
Cambodia	Lesotho	Swaziland
Cameroon	Liberia	Tajikistan
Central African Republic	Malawi	Thailand
Chad	Moldova (Rep)	Uganda
China	Mozambique	Ukraine
Congo, Democratic Republic of	Myanmar	UR Tanzania
Ethiopia	Namibia	Uzbekistan
Ghana	Nigeria	Vietnam
Guinea-Bissau	Pakistan	Zambia
India	Papua New Guinea	Zimbabwe

Student Name _____ R # _____

PART 5. TUBERCULOSIS TEST -- IF REQUIRED BY PART 4, MUST BE COMPLETED BY HEALTHCARE PROVIDER

If a test is required, it must be performed within 6 months from the first day of classes.

Has patient ever had a positive tuberculin skin test or blood test? ☐ Yes ☐ No

If No: complete Section A **If yes**: Date:_____ Result:_____ complete Section B & C

Has patient ever had BCG*? ☐ Yes ☐ No

***Students who have had BCG are still required to have a TB test**

Section A: Tuberculin Test - (Skin test OR blood test)

Please record actual mm of induration, transverse diameter; if no induration, write "0".

Skin Test: Date Placed:__/__/__ Date Read:__/__/__ Result: _____mm

Step II Date Placed:__/__/__ Date Read:__/__/__ Result:_____mm

OR

Blood Test: B Immunoassay blood test Date:__/__/__ Result: ☐ Negative ☐ Positive

Section B: Chest X-Ray is required if TB test is positive or if history of positive TB test and no chest x-ray report.

A copy of the chest x-ray report and/or documentation of treatment must accompany this form

A new chest x-ray is not required if patient is currently undergoing or has completed LTBI treatment.

Date of Chest X-Ray:__/__/__ Result: ☐ Normal ☐ Abnormal

Section C: Treatment for TB or LTBI

Documentation of treatment must accompany this form

Date treatment started: __/__/__ Date treatment completed: __/__/__

Name of medication:_____

Healthcare Provider Initials: _____

PART 6. REQUIRED IMMUNIZATIONS -- to be completed by a healthcare provider WHO must also complete and sign PART 8

TETANUS-DIPHTHERIA Booster must have been given within the past 10 years

__/__/__ (Tdap) **OR** __/__/__ (Td)

MEASLES, MUMPS, RUBELLA (MMR) **1)**__/__/__ **(2)**__/__/__

2 doses required at least 1 month apart. First dose must be given on or after one year of age; and after 1971 for combined MMR vaccine or after 1967 for individual doses

OR **ALL 3 OF THESE CRITERIA ARE MET:**

Measles (Rubeola)	**1)**__/__/__	**(2)**__/__/__
Mumps	**1)**__/__/__	**(2)**__/__/__
Rubella (German Measles)	**1)**__/__/__	**(2)**__/__/__

☐ **OR** Copy of titer lab work indicating **positive** immunity must accompany this form

HEPATITIS B (HBV) Must receive all three doses at appropriately spaced intervals to be considered fully immunized

(1)__/__/__ **(2)**__/__/__ **(3)**__/__/__

Check One ☐ Hepatitis B ☐ Twinrix ☐ Hepatitis B ☐ Twinrix ☐ Hepatitis B ☐ Twinrix

OR ☐ Copy of titer lab work indicating **positive** immunity must accompany this form

OR ☐ signed waiver on page 4 of this form

Student Name _____ G # _____

PART 7. RECOMMENDED IMMUNIZATIONS -- to be completed by a healthcare provider who must also complete and sign PART 8

VARICELLA (chicken pox)	**(1)** ___/___/___	**(2)** ___/___/___	
HUMAN PAPILLOMAVIRUS (HPV)	**(1)** ☐ ___/___/___	**(2)** ___/☐/___	**(3)** ___/___/___
HEPATITIS A (If Twinrix, see Part 6, Hepatitis B)	**(1)** ___/___/___	**(2)** ___/___/___	
OTHER	**(1)** ___/___/___	**(2)** ___/___/___	**(3)** ___/___/___

PART 8. HEALTHCARE PROVIDER INFORMATION AND SIGNATURE, ALL INFORMATION REQUIRED

Transcribed Records Administered Vaccine(s)

Printed Name and Title			
Name of Practice or Clinic			
Address			
Phone Number			
Health Care Provider Signature		Date	

WAIVER OF IMMUNIZATION AGAINST HEPATITIS B DISEASE

Hepatitis B is a serious liver disease caused by the hepatitis B virus (HBV). HBV infection can affect people of all ages and lead to liver disease. The virus is found in the blood and body fluids of infected people it is most often spread among adults through sexual contact or by sharing needles and other drug paraphernalia with an infected person. HBV can also be spread in households of HBV-infected persons or by passage of the virus from an HBV-infected mother to her infant during birth. Hepatitis B can be a silent disease, often infecting many people without making them feel sick. Unfortunately, 30 percent of those infected with HBV are not aware that they are carriers and can infect others. Hepatitis B symptoms might include loss of appetite, fatigue, stomachache, nausea and vomiting, yellowing of the whites of the eyes (jaundice), and/or joint pain. Vaccination can help prevent people from contracting hepatitis B. The HBV vaccine is 96 percent effective following a series of three shots over a six-month period. The most common side effect of the vaccine is soreness at the injection site. Vaccine recipients cannot get the disease from the vaccine.

*I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at anytime at my own cost. I have received and reviewed the information regarding hepatitis B and the availability and effectiveness of the hepatitis B vaccine. I have chosen **not** to be vaccinated (or I am unable to provide current vaccination records) against hepatitis B.*

_____ _____ _____ _____

Student Signature Date Parent/Guardian Signature, if student is a minor Date

EXEMPTIONS PERMISSABLE: DO NOT APPLY TO TUBERCULOSIS SCREENING/TESTING

Medical: Letter from healthcare provider must accompany this form. Religious Exemption: Original, notarized form required.