

**Ohio University School of Nursing  
Immunization Record Form**

**This is one of the forms that must be completed and returned to the School of Nursing  
before the end of the second week of NRSE 300.**

**NAME:** \_\_\_\_\_ **Date:** \_\_\_\_\_

<p><b>1. Rubella</b> (German Measles) Must have one dose of vaccine <b>OR</b> a positive titer</p>	<p>Immunization Date: _____ <b>OR</b></p> <p>Titer results: _____ Date: _____</p>
<p><b>2. Rubeola</b> (Measles): All persons born on or after 1/1/57 must show proof of 2 measles vaccination <b>OR</b> a positive titer <b>OR</b> documentation of disease by physician</p>	<p>Immunization date #1: _____ Immunization date #2: _____</p> <p>Titer results: _____ Date: _____</p>
<p><b>3. Mumps:</b> Must have immunization <b>OR</b> titer <b>OR</b> history of disease</p>	<p>Immunization date: _____ Titer results: _____ Date: _____</p>
<p><b>4. Tetanus &amp; Diphtheria:</b> Primary series in childhood</p>	<p>Immunization date #1: _____ Immunization date #2: _____ Immunization date #3: _____ Immunization date #4: _____</p>
<p><b>5. Tetanus:</b> Booster within past 10 years required. <b>Tdap recommended</b></p>	<p>Date: _____</p>
<p><b>6. Polio:</b> Primary series in childhood <b>OR</b></p> <ul style="list-style-type: none"> <li>• If vaccinated but unable to provide documentation, you need to provide documentation of one polio injection (IPV)</li> <li>• If never vaccinated you are required to provide documentation of completion of a series of 3 polio injections over the period of 6 months</li> </ul>	<p>Immunization date #1: _____ Immunization date #2: _____ Immunization date #3: _____</p> <p>IPV (if indicated): _____</p>
<p><b>7. Chicken Pox:</b> Must have had the disease <b>OR</b> positive Varicella antibody <b>OR</b> have had 2 doses of Varicella vaccine</p>	<p>History of disease (circle one): YES NO</p> <p>Vaccine #1: _____ Vaccine #2: _____</p> <p>Titer: _____ Date: _____</p>
<p><b>8. TB screening (Mantoux &amp; updated annually)</b></p> <p>** If there is a past history of a positive PPD a chest x-ray is required.</p>	<p>Results: _____ Date read: _____</p> <p>Results of chest x-ray: _____</p>
<p><b>9. Hepatitis B vaccine:</b> Three doses <b>OR</b> positive antibody. If taking series must have a signed waiver on file until series is completed.</p> <p>In process: _____ Waiver on file; _____</p>	<p>Dose #1 date: _____ Dose #2 date: _____ Dose #3 date: _____</p> <p><b>OR</b></p> <p>HbsAG results: _____ Date: _____</p>