



Immunizations – Part I

Name: _____ SSN or LSCPA ID#: _____

Program: Certified Nurse Aide Date of Birth: _____

Measles (Rubeola):	
A. Two doses of measles vaccine on or after their first birthday and at least 30 days apart OR	Date #1 _____ Date #2 _____ (mm/dd/yy) (mm/dd/yy)
B. Serologic test positive for measles antibody	Date _____ Result _____ (mm/dd/yy)
Combined MMR Vaccine is vaccine of choice if recipients are likely to be susceptible.	
Mumps:	
A. Two dose of mumps vaccine on or after their first birthday and at least 30 days apart OR	Date #1 _____ Date #2 _____ (mm/dd/yy) (mm/dd/yy)
B. Serologic test positive for mumps antibody	Date _____ Result _____ (mm/dd/yy)
If TB Skin Test (PPD) is also needed, if it is not administered on the same day as the required vaccines, the student must wait to have the PPD administered 30 days after receiving the vaccines.	
Rubella:	
A. One dose of Rubella vaccine on or after their first birthday OR	Date _____ (mm/dd/yy)
B. Serologic test positive for Rubella antibody	Date _____ Result _____ (mm/dd/yy)
Tdap Vaccine required once only: Note: After Tdap, TD booster every 10 years. Indicate clearly this is Tdap and not Dtap	Date _____ (mm/dd/yy)
Flu Shot One dose required during flu season	Date _____ (mm/dd/yy)
Hepatitis B. Must show proof of:	
A. The minimum interval between the first two doses is 4 weeks, and the minimum interval between the second and third doses is 8 weeks. However, the first and third doses should be separated by no less than 16 weeks. It is not necessary to start the series or add doses because of an extended interval between doses. OR	Date #1 _____ (mm/dd/yy)
	Date #2 _____ (mm/dd/yy)
	Date #3 _____ (mm/dd/yy)

B. Serologic test positive for Hepatitis B antibody Date _____ Result _____
(mm/dd/yy)



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Varicella: Must show proof of:	
A. Two doses of Varicella vaccine administered 4-8 weeks apart OR	Date #1 _____ Date #2 _____ (mm/dd/yy) (mm/dd/yy)
B. Serologic test positive for Varicella antibody OR	Date _____ Results _____ (mm/dd/yy)
C. Physician documented history or diagnosis of Varicella. Documented history after September 1, 1991 must have a month, day and year	Date Disease Occurred _____ (mm/dd/yy)
Only one dose of Varicella vaccine is needed if the student received first dose before the age of thirteen (13). Measles, Mumps, Rubella (MMR)/Varicella vaccines if not given on the same day MUST be 30 days apart.	

IMPORTANT INFORMATION: Vaccines administered after September 1, 1991 shall include the MM/DD/YY each vaccine was given.

Physician or Approved Licensed Health Professional Information:	
Printed Name	
Address	
Signature of Primary Care Provider (Signature and Date only validates vaccinations)	Date



Immunization – Part II & Criminal Background Check Required by State Law/Clinical Facilities

Name: _____ SSN or LSCPA ID#: _____

Program: Certified Nurse Aide Date of Birth: _____

<p>Criminal Background Check Please indicate the date you submitted your request to https://weborder.precheck.net/studentcheck/studentmain.aspx for PreCheck to conduct the background check. Select the program for which you applying, if program is not listed please select "Health Professions CE Background Check Only"</p>	<p>Date _____ (mm/dd/yy) Must be current within 3 months of your skills lab/practicum/clinical start date.</p>
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**See excerpt from CDC website below from Latent Tuberculosis Infection Tuberculosis. Must show proof of:

<p>A. Documentation of negative (<10mm) two-step tuberculin skin test (TST) must be current within 3 months of your skills lab/practicum/clinical start date</p> <p>OR</p>	<p>Date Given: #1 _____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative (If negative, repeat in 1- 3 weeks) Read by: _____ Date: _____ Date Given: #2 _____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative Read by: _____ Date: _____</p>
<p>A. Negative blood assay (QFT, TSPOT) must be current within 3 months of your skills lab/practicum/clinical start date</p>	<p>Date _____ Results _____ (mm/dd/yy)</p>
<p>B. IF a prior positive reactor to TST, must show documentation of a negative blood assay within 90 days</p>	<p>Date _____ Results _____ (mm/dd/yy)</p>
<p>C. IF prior positive blood assay, present a negative chest x-ray within past 2 years, be free of productive cough, night sweats or unexplained loss of weight. (submit Disease Screening TB Questionnaire)</p>	<p>Date: _____ (mm/dd/yy) X-ray results: _____</p>

****This is required by our clinical agencies – no exceptions. "Some people infected with M. tuberculosis may have a negative reaction to the TST if many years have passed since they became infected. They may have a positive reaction to a subsequent TST because the initial test stimulates their ability to react to the test. This is commonly referred to as the "booster effect" and may incorrectly be interpreted as a skin test conversion (going from negative to positive). For this reason, the "two-step method" is recommended at the time of initial testing for individuals who may be tested periodically (e.g., health care workers)."**

Physician or Approved Licensed Health Professional Information:	
Printed Name	
Address	
Signature and Date of Primary Care Provider (only validates Tuberculosis info above)	Date