Ila Faye Miller School of Nursing & Health Professions

STUDENT IMMUNIZATION RECORD | *Please have the following form completed and signed by your healthcare provider. Sentry MD will also accept separate documents from your provider for any requirements on the form as long as they are documented properly by the provider or clinic.*

NAME (print or type):_____ **Date of Birth:** _____

UIW ID#:_____ **Contact Phone #:** _____

Program entering: □ **Undergraduate** □ **Graduate**

HEPATITIS B ONLY *OR* HEPATITIS A&B COMBO VACCINE

D A T E: 1.)_____ 2.)_____ 3.)_____

AND

Hepatitis B Antibody Titer: Date:_____ Immune:_____ Not Immune:_____ Value:_____

TUBERCULOSIS (TB Screen/PPD)

Date Placed:_____ Date Read:_____ Results:_____mm_____Positive_____Negative

OR

QUANTIFERON TB GOLD *or* TSpot

Results: _____Positive _____Negative

If positive reading

CXR Results:_____ Date:_____

For office use only
Current TB screening or TB Physical exam:

Date:_____	Date:_____	Date:_____
Date:_____	Date:_____	Date:_____

VARICELLA (Chickenpox)

1ST Immunization date:_____ 2nd Immunization date:_____

OR

Varicella Titer Date:_____ Immune:_____ Not Immune:_____ Value:_____

MEASLES (RUBEOLA), MUMPS, and RUBELLA

1st Immunization Date:_____ 2nd Immunization Date:_____

O R

Measles Titer Date:_____	Immune:_____	Not Immune:_____	Value:_____
Mumps Titer Date:_____	Immune:_____	Not Immune:_____	Value:_____
Rubella Titer Date:_____	Immune:_____	Not Immune:_____	Value:_____

Tdap (Tetanus, Diphtheria, & Pertussis)	**FLU** (During current flu season only)	**COVID VACCINE(S): May be required by certain agencies for practicum)**
Booster Date:_____	Date:_____	**CIRCLE**: Pfizer Moderna J&J Date 1:_____ Date 2:_____

By signing below, I certify that the information above is true and correct:

PROVIDER NAME (print):_____ Title (RN, APRN, PA, MD, or DO): _____

Signature:_____ Date:_____

Daytime Phone: ( )_____

For office use only
Reviewer signature:_____ Date:__