

**CATTARAUGUS-ALLEGANY BOCES
PRACTICAL NURSING PROGRAM
IMMUNIZATION RECORD**

NAME _____

All students must be in compliance with the New York State Department of Health Immunization Law as related to health care workers. We must have documentation of the immunizations listed below:

MEASLES, MUMPS, RUBELLA - Anyone born after January 1, 1957 must show documentation of **TWO** vaccinations for measles, **ONE** for mumps and **ONE** for rubella. You may be able to provide blood test results (titers) that demonstrate immunity to any of these diseases. The date and test result must be listed. Anyone born before 1957 must provide documentation of one vaccination for the above 3 diseases (or titers showing immunity to these disease). In lieu of vaccinations, you may be able to provide a **DOCUMENTED HISTORY** of the disease. This means a certificate of diagnosis as having had the disease as prepared by the physician, nurse practitioner or physician's assistant who diagnosed the disease.

A minimum of 90 days before the first clinical rotation would be needed for rubella vaccine administration and recheck of titer level if initial titers indicate non-immunity. You will **NOT** be permitted to attend clinical sessions until these requirements are met.

VARICELLA (Chickenpox) You must provide documentation of immunity for varicella. You may provide blood test results (titers) that demonstrate immunity to the disease, date of varicella vaccination, date of disease or sign the waiver form on the reverse page .

HEPATITIS B VACCINE - This is a 3-vaccine series that is highly recommended for health care workers. If you choose not to receive this vaccination, the waiver form on the reverse page must be signed.

TETANUS BOOSTER - You must have had within the past 10 years. If you have not, you need one before admission to the program.

INFLUENZA/H1N1 VACCINE – A seasonal flu vaccine and H1N1 vaccine is highly recommended by all healthcare agencies. Anyone who declines these vaccines must wear a mask during direct patient care.

TUBERCULIN TEST (Mantoux) – The clinical facilities require a Two-Step Mantoux skin test for any student who has not been tested on an annual basis. If the student hasn't had a Mantoux test for the last two years in a row, a second Mantoux skin test (at least two weeks after the first test) will be needed. Please indicate test dates AND test results. This is an annual test and must be within the current calendar year. If the TB test is read as positive, or the student has a prior history of a positive Mantoux, further appropriate clinical follow-up is necessary.

	Vaccination Date		Titer Date/Results
Measles	#1	#2	OR
Mumps			OR
Rubella			OR
Hepatitis B Vaccine	1 st Dose:		} OR
	2 nd Dose:		
	3 rd Dose:		
Tetanus Booster – within 10 years			

	Date of Disease	Date of Vaccine	Titer Date/Results
Varicella (Chickenpox)	OR	OR	

	Vaccination Date	Vaccination Date	Vaccination Date
Influenza Vaccine – within 1 year		H1N1 Vaccine – within 1 year	

	1 st Test Date	Results (Induration by mm)	2 nd Test Date	Results (Induration by mm)
Tuberculin Test (Mantoux)				

I declare that the information on this form is true and correct.

Date

Student Signature

**CATTARAUGUS-ALLEGANY BOCES
SCREENING/VACCINE REFUSAL**

Hepatitis B Declination

I understand that my clinical experience carries the risk of exposure to the Hepatitis B virus. I also understand that persons who contract Hepatitis B have a risk of developing chronic hepatitis, cirrhosis of the liver, liver failure with resultant death and other less frequent chronic debilitating diseases.

I also understand that Hepatitis B may be transmitted to my spouse or sexual partner, and that it could affect my unborn child if I am pregnant.

I understand that there is a synthetic vaccine available which has minimal side effects and a very high safety profile. I have had an opportunity to review available literature about Hepatitis B, and my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base an informed consent. At this time, however, I choose not to be vaccinated.

Student Signature

Date

Varicella Declination

Please read and sign the following statement if you refuse to be screened and/or vaccinated for Varicella.

I, _____, understand the purpose and advisability of the Chickenpox immunization, and with full understanding of the risks to myself, I have decided against immunization. I understand that if I am exposed to active Varicella I will be required to stay out of the clinical area for the twenty-one (21) day incubation period.

I refuse the Varicella Titer and/or Vaccination.

Student Signature

Date