Bon Secours
Memorial College of Nursing
Southside College of Health Sciences
St. Mary's Hospital School of Medical Imaging

IMMUNIZATION RECORD

Effective Date: 04/05/2023

Last Name (Please Print):_____ First Name:_____ Date of Birth:_____

This form must be completed and signed by a Healthcare Provider to be acceptable as proof of your immunization information.

MEASLES, MUMPS & RUBELLA (MMR)		**Month**	**Date**	**Year**	**Signature/Results**
	Measles Dose #1:				Provider Signature:
	Measles Dose #2:				Provider Signature:
	OR Measles Antibody Titer:				Reactive / Non-Reactive
	Mumps Dose #1:				Provider Signature:
	Mumps Dose #2:				Provider Signature:
	OR Mumps Antibody Titer:				Reactive / Non-Reactive
	Rubella Dose #1:				Provider Signature:
	Rubella Dose #2:				Provider Signature:
	OR Rubella Antibody Titer:				Reactive / Non-Reactive
VARICELLA (Chicken Pox)		**Month**	**Date**	**Year**	
	Varicella Dose #1:				Provider Signature:
	Varicella Dose #2:				Provider Signature:
	OR Varicella Antibody Titer:				Reactive / Non-Reactive
HEPATITIS B - I have had the series		**Month**	**Date**	**Year**	**Results**
	Vaccine Series Type (circle one): 2-dose / 3-dose				
	Hepatitis B Dose #1:				Provider Signature:
	Hepatitis B Dose #2 (concludes here if 2-dose series):				Provider Signature:
	Hepatitis B Dose #3:				Provider Signature:
	OR Hepatitis B Antibody Titer:				Reactive / Non-Reactive
	If titer is **negative** and student has no previous Hepatitis B vaccine record, they will proceed to receive a full 2- or 3-dose series				
HEPATITIS B - I have NOT had the series		**Month**	**Date**	**Year**	**Signature**
	Vaccine Series Type **(circle one)**: 2-dose / 3-dose				
	Hepatitis B Dose #1:				Provider Signature:
	Hepatitis B Dose #2 (concludes here if 2-dose series):				Provider Signature:
	Hepatitis B Dose #3:				Provider Signature:
TB SCREENING - PPD Skin Tests unacceptable		**Month**	**Date**	**Year**	**Screening Results (circle one)**
	T-Spot				Positive / Negative
	QuantiFERON Gold Test				Positive / Negative
	If positive: Chest X-ray				Provider Signature:
TDAP (Tetanus, Diptheria & Pertussis)		**Month**	**Date**	**Year**	**Signature**
	Must be within the last 10 years				Provider Signature:

PHYSICIAN INFORMATION:

NAME:

SIGNATURE:

DATE:

(Stamp Acceptable)

APPLICANT/STUDENT SECTION: I hereby authorize the release of my medical records to CastleBranch to meet the requirements set by my Richmond Higher Education Institution. I do this with the understanding that my personal information will not be disseminated for any other purpose than those specified by my educational institution. By affixing my signature, I grant full consent for the duration of my enrollment. I am aware that I can revoke my consent, in writing, at any time.

STUDENT SIGNATURE: