

University of Houston-Victoria School of Nursing
Student Immunization Verification

Name _____ Date of Birth _____
Last First MI

Current Mailing Address _____ Phone () _____
Street

City/State Zip

Nursing Program: Second Degree RN-BSN MSN DNP

Student Instructions:

Make an appointment with a primary care provider of your choice such as a physician or a nurse practitioner. Bring this form to the provider to be filled out and signed when all of the requirements have been met. Plan to provide the provider with evidence of the requirements or obtain the requirements at the appointment(s). Complete the appropriate information at the bottom of the form. The cost of obtaining these requirements is the responsibility of the student. Mail this completed and signed form to the UHV School of Nursing one week prior to the application deadline.

Provider Instructions:

Thank you for evaluating the immunization status of a UHV School of Nursing applicant. Please indicate if the student has met each of the following requirements by filling in the information requested and then completing the information at the bottom of the form.

Immunizations Required for Admission to UHV SON

Immunizations	Requirements
Varicella (Chickenpox)	Date of first immunization _____ THEN Date of second immunization _____ (not required for admission) OR Date and result of varicella Titer _____ Immune _____ Not immune _____ OR Date of disease _____ (verbal report is not acceptable proof of disease)
Mumps	Date of mumps vaccine _____ OR Date and Result of mumps titer _____ Immune _____ Not immune _____
Measles (Rubeola)	Date of first measles vaccine _____ AND Date of second measles vaccine _____ OR Date and Result of measles titer _____ Immune _____ Not immune _____
Rubella	Date of rubella vaccine _____ OR Date and Result of rubella titer _____ Immune _____ Not immune _____
Tetanus/Diphtheria	Date of tetanus/diphtheria vaccine _____ OR Date and Result of tetanus/diphtheria titer _____ Immune _____ Not immune _____
Hepatitis B	Date of first immunization _____ THEN Date of second immunization _____ (not required for admission)

	THEN Date of third immunization _____ (not required for admission) OR Date and result of hepatitis B titer _____ Immune _____ Not immune _____
Tuberculosis Skin Test (PPD)	Date of Tb skin test _____ AND Date of Tb skin test reading _____ POS _____ NEG _____ OR Date of Chest X-Ray _____ Results _____ (evidence of BCG vaccination does not meet this requirement)
Flu Shot	Date of influenza vaccine _____

Provider Name (Print) _____

Address _____ Phone () _____
Street City/State Zip

Title _____ Date _____ Signature _____

Student Name (Print) _____

I acknowledge by my signature below that all the data provided here is accurate and is verification of my personal immunization and Tb status. I give consent for the release of my immunization records to the faculty of University of Houston-Victoria School of Nursing and to any clinical facilities that may provide clinical rotations for me.

 Student/Applicant Signature