ALAMO COLLEGES DISTRICT
St. Philip's College
Nursing Education Department

Immunizations and Tests Required by St. Philip's ADN Program and Clinical Facilities

Name: _____ **Banner ID#:** _____

Program: LVN/Military to ADN Mobility Program **Date of Birth:** _____

Please have your physician's office fill out this document, sign at the bottom for verification and ***attach a copy*** of all results listed in the medical records to be considered for the LVN/Military to ADN Mobility Program.

***Measles, Mumps, Rubella (MMR)/Varicella vaccines if not given on same day MUST be 28 days apart.**
ALL DATES MUST INCLUDE MONTH, DAY, AND YEAR.

Measles (Rubeola), Mumps & Rubella (MMR)	**A.** **Two** doses of Measles, Mumps, Rubella (MMR) vaccine on or after their first birthday and at least 28 days apart **OR**	Date #1: Date #2:
	B. Serologic test positive for Measles antibody	Date of Collection: ____Positive Result ____Negative Result
	B. Serologic test positive for Mumps antibody	Date of Collection: ____Positive Result ____Negative Result
	B. Serologic test positive for Rubella antibody	Date of Collection: ____Positive Result ____Negative Result
Varicella	**A.** **Two** doses of Varicella vaccine on or after their first birthday and at least 28 days apart**.** **OR**	Date #1: Date #2:
	B. Serologic test positive for Varicella antibody	Date of Collection: ____Positive Result ____Negative Result

Hepatitis B	**A.** **Recombivax HB or Engerix-B Vaccine** (initial dose) **A.** **Recombivax HB or Engerix-B Vaccine** Dose 2 (minimum 4 weeks after date #1) **A.** **Recombivax HB or Engerix-B Vaccine** Dose 3 (minimum 8 weeks after date #2 ***and*** minimum 16 weeks after date #1) **OR**	Date #1: Date #2: Date #3:
	B. **Heplisav-B Vaccine** (initial dose) **B.** **Heplisav-B Vaccine** Dose 2 (minimum 4 weeks after date #1) **OR**	Date #1: Date #2:
	C. Serologic test positive for Hepatitis B antibody	Date of Collection: ☐ Positive Result ☐ Negative Result

Tdap	**A.** Tdap—received after 6/10/05	B. Td—if Tdap is 10+ years old (must list both dates)	Date (Tdap): Date (Td):

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Additional Requirements:

Influenza	**A.** Influenza Vaccine Lot number: _____ Expiration Date: _____	Date Given:

Tuberculosis	**A. Documentation of a negative (<10mm) tuberculin skin test (TST) within the past 90 days prior to beginning the Program** **OR**	Date Given: #1 _____ Read by: _____ Date: _____ ☐ Positive ☐ Negative
	B. Negative blood assay (QFT, TSPOT) within the past 90 days prior to beginning the Program **OR**	Date: _____ Result: _____
	C. IF prior positive blood assay, present a negative chest x-ray report within past 2 years (this must not expire prior to, or during your first semester), be free of productive cough, night sweats or unexplained loss of weight.	Date of X-Ray Collection: _____ ☐ Positive Result ☐ Negative Result

COVID	**A. Pfizer** **OR**	Date #1: Date #2: Date #3:
	B. Moderna **OR**	Date #1: Date #2: Date #3:
	C. Johnson & Johnson	Date #1: Date #2:

Physician or Approved Licensed Health Professional Information: Validates all information above.	
Printed Name	
Office Address	
Signature	Date

*Attach copy of vaccination record.