

**GEORGIA SOUTHERN UNIVERSITY  
SCHOOL OF NURSING  
IMMUNIZATION FORM**

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**Student Name**

**Date of Birth**

**Eagle ID #**

**School of Nursing Required Immunizations or Tests:**

(Must be completed prior to enrollment in the first nursing course)

**Tuberculin Skin Test (PPD)** Date: \_\_\_\_\_ Result: \_\_\_\_\_

Provider Signature \_\_\_\_\_ Title \_\_\_\_\_

Agency \_\_\_\_\_

**Chest x-ray required if PPD is positive\*** Date: \_\_\_\_\_ Result \_\_\_\_\_

\*Attach summary from health care provider regarding follow-up of any positive PPD.

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**Hepatitis B**

Dose #1 Date: \_\_\_\_\_ Provider Initials \_\_\_\_\_ Agency \_\_\_\_\_

Dose #2 Date: \_\_\_\_\_ Provider Initials \_\_\_\_\_ Agency \_\_\_\_\_

Dose #3 Date: \_\_\_\_\_ Provider Initials \_\_\_\_\_ Agency \_\_\_\_\_

or Immune titer Date: \_\_\_\_\_ Result \_\_\_\_\_

or Vaccine refusal Date: \_\_\_\_\_ **Attach Form**

Waiver form for incomplete series Date: \_\_\_\_\_ **Attach Form**

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**MMR (Measles, Mumps, Rubella) Booster**, if born after 1957 or laboratory evidence of immunity to measles and rubella:

Dose 1 - immunized at 12 months of age or later Date: \_\_\_\_\_

and Dose 2 - immunized at least 30 days after Dose 1 Date: \_\_\_\_\_

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Tetanus within previous ten years: *(this can be satisfied with the university required tetanus/diphtheria)* Date: \_\_\_\_\_

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Print or type name and address of health care provider completing this form.

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Name

Address

Title

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City or Town

State

Zip

Phone

Immunization status above is certified by:

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Signature of Health Care Provider

Date Signed