College of Nursing Immunization Requirements:

The required vaccinations are listed below. Please submit this form directly to Student Health Services once the entire form is completed by your primary care provider. Once the Student Health Services processes your records, you can monitor your compliance status through the College of Nursing Student Portal.

Submission Instructions:

- Once this form is completely filled out by your health care provider, this form and **all required supporting documentation** must be uploaded through MyBuckMD. Vaccination records should not be submitted to the Office of Student Affairs, Equity and Inclusion through concompliance@osu.edu
- All medical documentation for compliance should be submitted at once utilizing this form with the exception of those students who are being revaccinated for Hep B.
- This form will be kept in your medical record at Student Health Services. Student Health Services will exchange health information with your academic program only for purposes of determining compliance with program requirements under the Family Educational Rights and Privacy Act (FERPA).
- If you have any questions regarding specific immunization requirements, please contact the

  Preventive Medicine Coordinator: 614-247-2387 or preventivemedicine@osu.edu.
- Please allow Student Health Services 1-2 weeks for processing of records. During times of high volume, this processing time may be longer.
- Non-health related compliance requirements submitted to Student Health Center will not be processed.

Full Name:______________________ Date of Birth:__________ Academic Program:____________

Requirement	Required Documentation		
Tuberculosis Screening Note: Annual renewal requirement only requires a 1-step test.	****2-step tuberculin skin test** Testing must meet the following criteria: • Must be **MANTOUX** (intradermal) PPD test • Must be read in 48-72 hours by a certified health care provider with results documented in mm.	PPD#1 date given: ________ PPD #1 date read: ________ Result: ____________ mm. Read by: ______________ Title: ________________	PPD #2 date given: ________ PPD #2 date read: ________ Result: ____________ mm. Read by: ______________ Title: ________________
<u>OR</u>	TB Blood test QTF-G (IGRA) *Recommended for those that have received the BCG vaccine*	☐ **Lab report attached.**	
	**Negative QTF-G (IGRA) within last year or negative CXR within last year required if previously tested positive on skin test. Please consult Preventive Medicine Coordinator at Student Health Services ASAP to determine appropriate next steps.		
Tdap (Tetanus, Diphtheria, Pertussis)	Date: ________________	Type: ________________	Provider initials: __________
	Required if have not received Tdap previously, regardless of when previous Td was administered ***Tdap must be re-administered every 10 years (TD booster accepted after initial Tdap vaccine)**		
Measles, Mumps, & Rubella (MMR)	2 doses MMR vaccine MMR #1 date: ____________ MMR #2 date: ____________	**OR** Individual vaccines Measles #1 date: __________ Measles #2 date: __________ Mumps #1 date: __________ Mumps #2 date: __________ Rubella #1 date: __________	Provider initials: __________
<u>OR</u>	Positive serum anti-body titers	☐ Lab report attached.	
	****MMR titers only recommended if proof of vaccination is unable to be located****		

Full Name:____________________ Date of Birth:__________ Academic Program:__________

Requirement	Required Documentation	
Varicella (Chicken Pox)	Dose #1 date: ________ Dose #2 date: ________	Provider initials: ________
OR	Positive serum anti-body titer	☐ Lab report attached.
	NOTE: History of disease is NOT acceptable evidence of immunization to varicella	
	****Varicella titer only recommended if previously infected with the disease (chickenpox), or proof of vaccination is unable to be located****	
Hepatitis B Note: Positive titer ***must*** be accompanied by documentation of 3-shot series	Dose #1 date: ________ Dose #2 date: ________ Dose #3 date: ________	Provider initials: ________ **Note: A positive titer must be accompanied by documentation of the 3-shot series**
AND	Positive serum anti-body titer	☐ **Lab report attached.**
	If the titer is negative, at minimum one dose AND the titer must be repeated. Contact your program coordinator ASAP if you receive a negative test to plan the next step toward gaining compliance.	
	NOTE: If repeating the vaccines due to a negative titer, we will also need proof of your original series	
Influenza	Dose date: ________	Provider initials: ________
	NOTE: Seasonal flu vaccines are typically available starting in August/September.	
Annual Drug Screen *10 or 12 panel required*	Completion Date:________	Results:________ ☐ **Lab report attached.**
Provider information Signature required for this document to be valid	Name: ________ Address: ________ ________ Phone: ________ Signature: ________ Date completed: ________	