Hennepin Technical College Nursing Program Immunization Form

Full Name:	**Date of Birth:**	**HTC Student ID:**

Dear Healthcare Provider,

This form, a requirement for entry into the nursing program at Hennepin Technical College, must be completed in its entirety, and signed by an MD, NP, PA, or Public Health Nurse. These are the current CDC recommendations for immunizations for health care workers and required for clinical at our partners. **Printouts of clinic records cannot be accepted in place of this form.**

MMR (Measles, Mumps and Rubella): Must have **ONE** of the following (check the appropriate box):

- □ Born before January 1st, 1957 ***OR***
- □ Vaccination with **TWO** doses after 12 months of age (at least 4 weeks apart):
  Date of 1st dose_____ Date of 2nd dose _____ ***OR***
- □ Titer indicating immunity of Measles, Mumps and Rubella: Date of titer* _____

**"Indeterminate" or "equivocal" levels of immunity upon testing should be considered non-immune.*

Varicella (Chicken Pox) immunity: Must have **ONE** of the following (check the appropriate box):

- □ Vaccination with **TWO** doses (at least 4 weeks apart):
  Date of 1st dose_____ Date of 2nd dose_____ ***OR***
- □ Varicella titer indicating immunity: Date of titer*_____

**"Indeterminate" or "equivocal" levels of immunity upon testing should be considered non-immune.*

Tetanus/diphtheria/pertussis (Tdap): **ALL must have the following:**

- □ One dose of Tdap after age 11: Date of vaccination*:_____

**Tdap can now be administered regardless of interval since the last tetanus or diphtheria-toxoid containing vaccine.*

Tetanus/diphtheria booster (Td): (check the appropriate box):

- □ Td **only if more than 10 years** since receiving any type of Tetanus/diphtheria or Tetanus/diphtheria/pertussis vaccine.
  Date of most recent Td or Tdap :_____ ***OR***
- □ Not applicable because a Td or Tdap or equivalent vaccine has been received within the last 10 years

Hepatitis B 3-dose series: Must have **ONE** of the following (check the appropriate box):

- □ At least **one dose is needed for program admission** [the remaining 2 doses can be completed after admission]
  Date of 1st dose (required)_____ [Date of 2nd dose_____ Date of 3rd dose_____]
  (For complete series: dose #1 now, dose #2 in 1 month, dose #3 approximately 5 months after 2nd dose) ***OR***
- □ Hepatitis B titer indicating immunity: Date of titer _____

Influenza: Must have most recent Influenza vaccination with the dates of Oct 1-March 31

- □ Date of most recent vaccination_____

Covid-19 2-dose series **ALL must have the following** (not eligible for exemption)

- □ Vaccination with **TWO** doses:
  Date of 1st dose_____ Date of 2nd dose_____ Date of 3rd dose _____

I certify this is an accurate record of the immunization history and affirms that the above-named student is approved for patient care.

Signature of MD, NP, or PA* _____ Date_____

(*signature of a primary care provider is required. Note: A public health nurse may sign for county public health clinics)

Medical exemption, if applicable: The student is unable to receive the following immunization(s) due to a medical condition _____

Signature of MD, NP, or PA _____Date_____