Marcella Niehoff School of Nursing
Faculty Health Requirements

Faculty name:_____ **DOB**:_____

Vaccination record

A. MMR Dates: 1) ___/___/___ 2) ___/___/___
If you did not receive the full MMR, indicate vaccinations received:

1). Measles (Rubeola): Dates: 1) ___/___/___ 2) ___/___/___
2). Mumps (Parotitis): Dates: 1) ___/___/___
3). German measles (Rubella): Date: ___/___/___
(OR disease confirmed by MD/NP record) ___/___/___

B. Chicken Pox (Varicella): Dates: 1) ___/___/___ 2) ___/___/___
(OR disease confirmed by MD/NP record) ___/___/___

C. Diptheria/Tetanus/Pertussis (DPT, Tdap or TD)
Primary series: Dates: 1) ___/___/___ 2) ___/___/___ 3) ___/___/___
Booster: Date: ___/___/___ (must be within past 10 years)

D. Polio Most recent immunization date: 1) ___/___/___
* If no immunization date is available, **IPV booster is needed**

E. Hepatitis B Dates: 1) ___/___/___ 2) ___/___/___ 3) ___/___/___
Or history of disease: Date: ___/___/___

F. TB screen Dates: 1) ___/___/___ Result _____
2) ___/___/___ Result _____
CXR date: ___/___/___ **Must attach X Ray report**
History of disease: Date: _____

Titer results (IGG Titers are required regardless of MMR Immunizations)
You must attach copies of lab reports

Required: Varicella: _____ Rubella: _____

Optional: Measles: _____ Mumps: _____ Hepatitis: _____

Exemptions
Exemption letter must be attached
Medical _____ Religious _____ Pregnancy _____

Healthcare provider verifying above information:

Print name:
Telephone:
Address:
City/State/Zip:

Signature: _____ Date: _____
[Healthcare provider]