

Santa Monica College - Nursing Student Health Requirements

Last Name: _____ Date of Birth: _____
 First Name: _____ Student ID No.: _____

For Health Care Provider Use Only: Immunity Verification

Name of Titer	Date	Numerical IgG Titer	Yes/No	For Low or Negative Titer - Date Vaccine Administered
Rubeola Titer		Results	Immunity	Vac 1 Date _____ Vac 2 Date _____
Mumps Titer		Results	Immunity	Vac 1 Date _____ Vac 2 Date _____
Rubella Titer		Results	Immunity	Vac 1 Date _____ Vac 2 Date _____
Varicella Titer		Results	Immunity	Vac 1 Date _____ Vac 2 Date _____
HepB Titer		Results	Immunity	Vac 1 Date _____ Vac 2 Date _____ Vac 3 Date _____
*If documentation of childhood polio vaccine series presented, no titer required				
Polio Titer *		Results	Immunity	Vac 1 Date _____ Vac 2 Date _____
Seasonal Flu Vac Date		Tdap Date		

2 Step TB Mantoux Test Or A Single Blood Test				
1st Step	2nd Step	Blood Test	X-ray Result	
Date Read _____	Date Read _____		X-ray Result _____	
TB Result _____	TB Result _____		X-ray Completed _____	

Please attach business card or professional stamp here

For Health Sciences Use Only: Follow Up Immunizations

Immunizations

Seasonal Flu Vac Date _____

2 Step / TB Mantoux Test Or A Single Blood Test

1st Step	2nd Step	Blood Test	X-ray Result
Date Read _____	Date Read _____		X-ray Result _____
TB Result _____	TB Result _____		X-ray Complete _____

Signature of Physician or Advanced Practice Nurse:

Date Signed _____