MURRAY STATE UNIVERSITY
SCHOOL OF NURSING
RN BSN PROGRAM
120 Mason Hall Murray KY 42071-3302
IMMUNIZATION AND HEALTH RECORD

Student Name: _____
Last First MI

Date of Birth: _____SS #_____

Health Care Provider: _____
Name --- Please Print

_____
Street

_____
City State Zip

Date: _____ _____
Signature of Provider/Agency

List date and provide documentation stapled to this form of last immunization or titer for:

Rubeola _____ Tetanus _____(under 10 yrs.) Mumps _____ Varicella _____ titer _____

Rubella _____ Hepatitis B _____ _____ _____

TB _____ skin test _____ results _____ xray (if needed) _____ results _____

Hepatitis Immunization Information

The following form is required to be completed by each nursing student before beginning his/her first clinical course. It is the responsibility of the student to change any information regarding immunization status before starting another clinical rotation. Area hospitals require that we maintain accurate, updated information on each student in order to satisfy contractual agreements. Failure to keep records current could result in dismissal from the nursing program.

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. It has been recommended to me that I be vaccinated with the hepatitis B vaccine at my own cost. However, I may choose not to be vaccinated at this time. I understand that in not being vaccinated, I continue to be at risk of acquiring hepatitis B, a serious disease.

I have been vaccinated or am in the process of taking the hepatitis B series.

Student Signature Date

I am not vaccinated and am not in the process of taking the hepatitis B series.

Student Signature Date

X

Print Name Signature Date

Reviewed 2/21/05 ASAP
Reviewed 3/14/05 Faculty Meeting
Revised 5/5/11

FORM 008