Congratulations on beginning your career as a professional nurse in the BSN program at Heritage University! During your program you will be in close contact with patients who are ill. You may be at high risk for certain infections, and if you become ill, you will risk transmitting infections to vulnerable populations.

For your safety and the safety of your patients, our clinical training site affiliation agreements require that you complete and document immunizations, as well as initial and annual testing for tuberculosis, as recommended by the Centers for Disease Control and Prevention (CDC) for Health Care Personnel.

**Complete the following steps to meet the immunization and TB screening requirements:**

1. Carefully and completely read the enclosed *Immunization Form*. It has details about all of the required immunizations for BSN students, along with acceptable documentation.

2. Carefully and completely read the *TB Screening Form*. This form includes the details about the initial and annual TB screening requirements. Follow the designated timeline.

3. Gather your immunization records. These records may be from multiple sources, such as childhood records and employee health summaries. If your immunization records are at a clinic or other health care facility, obtain a copy of those records.

4. Make an appointment with a health care provider. This could be your primary care provider, an employee health nurse at your place of employment, or another health care provider. You will need a provider to review and verify your records, and sign the required forms. Make a scanned copy of the documents you receive from the provider.

5. Scan and send via email the completed forms and required documentation to **sanchez_m1@heritage.edu**. Include in the body of your email: Your name, your HU Student ID#, and designate that you are a new BSN student at Heritage University. **Always keep a copy of the documentation for your personal records.** When your email is received, you will receive a confirmation reply from **sanchez_m1@heritage.edu**. In addition, the nursing director and administrative coordinator will send an email reply after scanned documents are reviewed to advise whether they are complete or whether we need further information. If you do not receive the reply in an email, your documents may not have been received; in that case, please resend them.

6. Make sure we receive all required documentation by August 12, 2015.

7. If your Hepatitis B series or titer is “in process,” go ahead and submit your documentation, and send additional information as you progress in the series. Email scanned copies of documentation for each dose of vaccine and the quantitative titer lab report to **sanchez_m1@heritage.edu**. Include in the text of your email: Your name, your HU Student ID#, and designate that you are in the BSN program. Keep a copy of each item for your personal records. **NOTE:** You’ll need a minimum of three doses of Hepatitis B vaccine, plus a quantitative titer. The CDC recommends that nursing students complete their three-dose series prior to contact with patients or body fluids. This means you should start meeting the requirement as soon as possible after admission to the BSN program.
1. **CHILDHOOD IMMUNIZATIONS:** A Primary childhood or adult series with DTaP/DTP/DT/Td **is required.**

2. **MEASLES (RUBEOLA):** **TWO** doses of measles-containing vaccine (*regardless of birthdate*), or a positive IgG antibody titer. The doses must be on or after age 12 months, at least one month apart and a live virus vaccine after 01/01/68, given without Immune Globulin. MMR must have been received in 1971 or later.

3. **MUMPS:** **TWO** doses of mumps-containing vaccine (*regardless of birthdate*) or a positive IgG antibody titer. The doses must have been received on or after the age of 12 months and at least one month apart. Mumps alone must have been live virus vaccine received after 01/01/80.

4. **RUBELLA (GERMAN MEASLES):** **ONE** dose of rubella (single antigen) vaccine on or after 12 months of age or a positive IgG antibody titer.

5. **VARICELLA:** **TWO** doses of varicella-containing vaccine given on or after 12 months of age and at least one month apart or positive Varicella IgG antibody titer. **History of disease will NOT be accepted. Only the vaccine or titer will meet requirements.**

6. **TETANUS-DIPHTHERIA-PERTUSSIS:** One dose of Tdap **is required within the past 10 years.** This vaccine became available in the U.S. in June 2005. **Note:** Td is a different vaccine, and **does not** substitute for Tdap. Titers are **NOT** accepted in lieu of Tdap vaccine.

7. **HEPATITIS B:** **THREE DOCUMENTED DOSES** of vaccine **AND a positive QUANTITATIVE Hepatitis B surface antibody titer (HBsAb, or anti-HBs).** The reference range is indicated on the lab report for quantitative results; a positive titer is equivalent to 10 mIU/mL or higher. Students who just started the series may note they are “in process” and forward documentation of further doses and **titer results** as soon as they become available. Those who have **incomplete or no documentation of their series must complete a valid 3-dose series followed by the titer.** It is recommended that students complete their 3-dose series prior to patient (or body fluid) contact in practicum/clinical settings. **Additional doses:** If more than 2 years have elapsed since a dose was given, we recommend an extra dose to boost antibodies to a detectable level. Then, draw the quantitative HbsAb titer 4-6 weeks later. If this titer is negative, testing for the **antigen** (HBsAg), a test of "carrier" status or prior exposure, may be indicated. If the HBsAg is negative, continue completing a 2nd series. Then re-check the HbsAb titer 4-6 weeks later. See the following algorithm for further details: [http://www.immunize.org/catg.d/p2108.pdf](http://www.immunize.org/catg.d/p2108.pdf)
AND

(Required): Positive quantitative Hepatitis B surface antibody (anti-HBs) titer:
Proof of series completion and negative titers, Non-responders must submit proof of a counseling visit with a health professional to discuss their status and implications, such as immunizations necessary at time of blood borne pathogen exposures and need for rigorous adherence to standard precautions.

HEPATITIS B DISEASE: Those who have had the disease must attach the following laboratory results: Hepatitis B surface antibody, Hepatitis B surface antigen, and Hepatitis B core antibody. Students who are carriers (positive HBsAg) must show proof of a personal counseling visit with a provider about their carrier status (including discussion of need for rigorous adherence to standard precautions).

8. INFLUENZA: Seasonal influenza vaccine is required between August and November each year. Waivers are given only for students who have valid medical contraindications. No other rationale for waiver will be accepted. A waiver request form (available from Heritage University Nursing Program) must be submitted annually. NOTE: Egg allergy is no longer a contraindication for most. Egg-free vaccine is available.

9. TUBERCULOSIS TEST (PPD): Initial Two-Step PPD is required within 6 months of starting the program. Subsequent TB testing will be required annually. If history of positive TB Test: documentation of TB result, chest x-ray results, and completion of treatment are required. Also, see Tuberculosis Screening Form for the Heritage University 2015-2016 BSN student.
Part I. STUDENT INFORMATION This section of the form to be completed by student.

Name: _____________________________
Last First
DOB: __/__/____ HU Student ID Number: _____________________________ Semester Starting: _____________________________
Mo Day Yr.

REQUIRED: Heritage University Department of Nursing follows the recommendations of the Centers for Disease Control and Prevention (CDC), which are listed on this form. It is the student’s responsibility to meet any requirements of a practice site that may differ from those recommended by the CDC. By signing below I acknowledge I have read and agree to comply with the immunization requirements.

*SIGNATURE: * _____________________________ DATE: ___/___/____
(required) Mo Day Yr.

Please attach copies, not original records—all documents used for administrative purposes will be destroyed. Always keep the original or a copy for your personal records. This form must be completed in its entirety and received prior to your deadline.

Return by PDF attachment to Sanchez_m1@heritage.edu

PLEASE COMPLETE ALL PAGES OF THIS PAGE FORM
NAME: ____________________________  HU STUDENT ID NUMBER: ____________________________

Part II. DOCUMENTATION OF IMMUNIZATION REQUIREMENTS: To be completed ONLY by Health Care Provider (HCP) This section of the form should not be signed by student, parent, or spouse.

Instructions for HCPs: Documentation of immunity (AS DEFINED ON THIS FORM) is REQUIRED. Please initial each section; signature and credentials are requested at the end of the form. Lab reports must be submitted for titers. All sections must be completed for school acceptance.

1. CHILDHOOD IMMUNIZATIONS: A Primary childhood or adult series with DTaP/DTP/DT/Td is required. Students are expected to have received the childhood polio series. An adult IPV booster is an acceptable alternative.

   The following question must be answered:
   Were childhood immunizations completed? (i.e. DPT/Polio; ok to have completed in adulthood as explained above)

   YES ☐  NO ☐  If YES, is this information by:
   VERBAL REPORT ☐  OR DOCUMENTED RECORDS ☐
   (records NOT reviewed)  (records reviewed)

   Provider’s initials:

2. MEASLES (RUBEOLA): TWO doses of measles-containing vaccine (regardless of birthdate), or a positive IgG antibody titer. The doses must be on or after age 12 months, at least one month apart and a live virus vaccine after 01/01/68, given without Immune Globulin. MMR must have been received in 1971 or later.

   #1  Mo  Day  Yr.
   AND
   #2  Mo  Day  Yr.

   Indicate type:
   ☐ Measles (single antigen vaccine)
   ☐ Measles/Rubella
   ☐ Measles/Mumps/Rubella
   (MMR not available in U.S. until 1971)

   OR Positive Rubeola IgG Antibody Titer:
   (LAB REPORT REQUIRED)  Mo  Day  Yr.

   Provider’s initials:

   If two MMRs were not documented in #2, please complete the following; otherwise skip to question #5 on the next page.

3. MUMPS: TWO doses of mumps-containing vaccine (regardless of birthdate) or a positive IgG antibody titer. The doses must have been received on or after the age of 12 months and at least one month apart. Mumps alone must have been live virus vaccine received after 01/01/80.

   #1  Mo  Day  Yr.  AND  #2  Mo  Day  Yr.
   (must be after 1/1/1980)

   Positive Mumps IgG Ab titer:
   (LAB REPORT REQUIRED)  Mo  Day  Yr.

   Provider’s initials:

4. RUBELLA (GERMAN MEASLES): ONE dose of rubella (single antigen) vaccine on or after 12 months of age or a positive IgG antibody titer.

   Mo  Day  Yr.

   OR Positive Rubella IgG Ab titer:
   (LAB REPORT REQUIRED)  Mo  Day  Yr.

   Provider’s initials:

PLEASE COMPLETE ALL PAGES OF THIS PAGE FORM
Required Immunizations for Heritage University BSN Program Students 2015-2016

NAME: ________________________________ HU STUDENT ID NUMBER: ____________________

5. **VARICELLA:** *TWO* doses of varicella-containing vaccine given on or after 12 months of age and at least one month apart or positive Varicella IgG antibody titer. *History of disease will NOT be accepted.* Only the vaccine or titer will meet requirements.

<table>
<thead>
<tr>
<th>AND</th>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>#2</td>
</tr>
<tr>
<td>Mo</td>
<td>Day</td>
</tr>
</tbody>
</table>

   (Varicella vaccine not available in U.S. until 3/1995)

   Provider’s initials:

6. **TETANUS-DIPHTHERIA-PERTUSSIS:** One dose of *Tdap* is required within the past 10 years. This vaccine became available in the U.S. in June 2005. *Note: Td is a different vaccine, and does not substitute for Tdap.* Titers are *NOT* accepted in lieu of Tdap vaccine.

   **Tetanus-Diphtheria-acellular Pertussis (Tdap)**

   Date: / / Provider’s initials:

   (One dose needed within past 10 years)

7. **HEPATITIS B:** *THREE DOCUMENTED DOSES* of vaccine *AND* a positive QUANTITATIVE Hepatitis B surface antibody titer (HBsAb, or anti-HBs). The reference range is indicated on the lab report for quantitative results; a positive titer is equivalent to 10 mIU/mL or higher. Students who just started the series may note they are “in process” and forward documentation of further doses and titer results as soon as they become available. Those who have incomplete or no documentation of their series must complete a valid 3-dose series followed by the titer. It is recommended that students complete their 3-dose series prior to patient (or body fluid) contact in practicum/clinical settings.

   **Dose #1 / / Dose #2 / / Dose #3 / / (optional, see below) Dose #4 / /**

   Provider’s initials:

   **Additional doses:** If more than 2 years have elapsed since a dose was given, we recommend an extra dose to boost antibodies to a detectable level. Then, draw the quantitative HbsAb titer 4-6 weeks later. If this titer is negative, testing for the antigen (HBsAg), a test of “carrier” status or prior exposure, may be indicated. If the HBsAg is negative, continue completing a 2nd series. Then re-check the HbsAb titer 4-6 weeks later. See the following algorithm for further details: http://www.immunize.org/catg.d/p2108.pdf

   **AND (Required): Positive quantitative Hepatitis B surface antibody (anti-HBs) titer:**

   Date: / / Indicate Reference Range Used: ☐ Int’l Units ☐ OR ☐ Index Value Provider’s initials:

   (LAB REPORT REQUIRED)

   **HEPATITIS B NON–RESPONDERS** are those with a negative HBsAb after *2 documented 3-dose series* of vaccine. In addition to proof of series completion and negative titers, Non-responders must submit proof of a counseling visit with a health professional to discuss their status and implications, such as immunizations necessary at time of blood borne pathogen exposures and need for rigorous adherence to standard precautions.

   **HEPATITIS B DISEASE:** Those who have had the disease *must attach the following laboratory results:* Hepatitis B surface antibody, Hepatitis B surface antigen, and Hepatitis B core antibody. Students who are carriers (positive HBsAg) must show proof of a personal counseling visit with a provider about their carrier status (including discussion of need for rigorous adherence to standard precautions).

8. **INFLUENZA:** Seasonal influenza vaccine is required between August and November each year. Waivers are given only for students who have valid medical contraindications. A waiver request form (available from Heritage University Nursing) must be submitted annually. *NOTE:* Egg allergy is no longer a contraindication for most. Egg-free vaccine is available.

   2015-2016 Seasonal Influenza vaccine Date: / / Indicate type: ☐ inactivated/injected vaccine ☐ live/nasal ☐ recombinant
9. **TUBERCULOSIS TEST (PPD):** Initial Two-Step PPD is required within 6 months of starting the program. Subsequent TB testing will be required annually. If history of positive TB Test: documentation of TB result, chest x-ray results, and completion of treatment are required. Also, see Tuberculosis Screening Form for the Heritage University 2015-2016 BSN student.

<table>
<thead>
<tr>
<th>Dose #1</th>
<th>/</th>
<th>/</th>
<th>Dose #2</th>
<th>/</th>
<th>/</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mo.</td>
<td>Day</td>
<td>Yr.</td>
<td>Mo.</td>
<td>Day</td>
<td>Yr.</td>
</tr>
</tbody>
</table>

**HEALTH CARE PROVIDER INFORMATION**

*NOTE: This section must be completed by HCP (MD, DO, NP, PA, RN or other appropriate designee) for authentication. Not to be completed by student or relative.*

I certify the accuracy of all immunizations and other information detailed on this 2-page form:

HCP’s Signature __________________________  Date ____________

HCP’s name printed/stamp of facility:  Phone #__________ __________________________
Professional Documentation for Clinical Students

All Nursing Education Students are responsible for completing the requirements listed below. Students are also responsible for providing and maintaining current professional documentation. Current records are required to attend clinical and failure to maintain records may result in disenrollment.

The following documentation must be submitted prior to starting a clinical/fieldwork rotation:

- **MMR (Measles/Mumps/Rubella):** Requirement is met if you have one of the following:
  - Immunization record listing two MMR shots after 1978
  - A blood test for immunity to measles, mumps, and rubella

- **Tdap (Tetanus, Diphtheria, and Pertussis):** Booster dose within last 10 years.

- **Hepatitis A:** Series of two injections initial does and the 2nd injection 6 months after the 1st.

- **Hepatitis B:** Series of three injections and post completion titer takes approximately 4-7 months to complete. Entering students are required to have at least the first two injections of the series prior to starting clinical.

- **Varicella (Chickenpox):** Requirement is met if you have one of the following:
  - Proof of 2 doses of Varicella vaccine
  - Proof of immunity by titer

- **Polio:** documentation of primary polio vaccine series.

- **Influenza:** Seasonal influenza vaccine is required.

- **Tuberculosis Test (PPD):** Initial Two-Step PPD is required within 6 months of starting the program. Subsequent TB testing will be required annually.
  - If history of positive TB Test: documentation of TB result, chest x-ray results, and completion of treatment are required.

- **BLS (Basic Life Support):** CPR and AED Program Card. Certification for American Heart Association (Adult, Child, & Infant)

- **AIDS/HIV Certificate:** Documentation of 7 hours of certified training
To submit documentation either:

- Scan documents and attach to an email: sanchez_m1@heritage.edu
- Mail to:

  Melissa Sanchez  
  c/o Heritage University, Dept. of Nursing  
  3240 Fort Rd., Toppenish, WA 98948

- Or bring by Melissa’s office in College of Arts and Sciences Building #2335.

Please direct any questions to Melissa Sanchez at sanchez_m1@heritage.edu or (509) 865-8551.

It is advised that students keep copies of all professional documentation for their own records. The CON will not make copies of documentation after it has been submitted. Students who lose their records will have to return to the original source to replace them.
Part I. STUDENT INFORMATION (please type or print legibly) This section of the form to be completed by student.

Name: ____________________________ ____________________________
Last First
DOB: / / HU Student ID Number: ____________________________ Phone #: ____________________________
Mo Day Yr

REQUIRED:
Heritage University Department of Nursing follows the Tuberculosis Screening recommendations of the Centers for Disease Control and Prevention (CDC) for Health Care Providers, which are listed on this form. By signing below I acknowledge I have read and agree to comply with the Tuberculosis Screening Requirements.

*SIGNATURE: *
______________________________________________
DATE: _______ / _______ / _______
(required)

Please attach copies, not original records—all documents used for administrative purposes will be destroyed. Always keep the original or a copy for your personal records. This form must be completed in its entirety and received prior to your deadline.

Return by PDF attachment to sanchez_m1@heritage.edu.

Part II. DOCUMENTATION OF INITIAL TB REQUIREMENTS: To be completed ONLY by Health Care Provider (HCP)

This section of the form should not be signed by student, parent, or spouse.

TUBERCULOSIS SCREENING: A “2-step” TB skin test (PPD) must be done on or after 6/1/2015. A 2-step test consists of 2 separate tests, placed and read at least 1, but not more than 3 weeks apart. History of BCG is not a contraindication to TB testing. Students with negative 2-steps must submit documentation of annual TB skin testing yearly after initial screening to maintain compliance. Chest X-rays are NOT accepted as substitutions for TB screening. IGRA (interferon gamma release assay, such as Quantiferon Gold) blood test results DO substitute for PPDs. Students electing the IGRA must continue with annual IGRA screening (as documented by lab report) unless they obtain a 2-step PPD. IGRAs prior to 6/1/2015, are not accepted for the 2015-16 school year.

Note: A PPD skin test must be placed, or IGRA must be drawn, the SAME day as any live virus vaccine (MMR, Varicella) being given OR, at least 28 days after the administration of a live virus vaccine, to be considered valid. Please plan for this if one of the live virus vaccines may be needed.

TEST (PPD) #1
Placed: / / Date Read: / / Result: ______mm
Mo Day Yr (read 48-72 hours after placement)

ON OR AFTER 6/1/2015

Signature/stamp of Health Care Provider: ____________________________

(For 2-step: If test #1 is negative, test #2 is done at least 1, but not more than 3 weeks later. If either test is positive, a chest x-ray is required.)

TEST #2 Placed: / / Date Read: / / Result: ______mm
Mo Day Yr (read 48-72 hours after placement)

Signature/stamp of Health Care Provider: ____________________________

OR

Date of Negative IGRA: / / ON OR AFTER 6/1/2015 (LAB REPORT MUST BE SUBMITTED WITH THIS FORM)

Mo Day Yr

Students: If you are submitting documentation of two negative TB skin tests signed above by a health care provider, or a negative IGRA blood test result (with lab report showing result attached) then you do not need to complete the second page of this form. You have finished and can submit this page.

FOR DOCUMENTED POSITIVE TB SCREEN COMPLETE BOTH PAGES OF FORM 04/25/15
Tuberculosis Screening Form for Heritage University BSN Students 2015-2016

NAME: _______________________________ HU STUDENT ID NUMBER: ____________

If TB screening results in a positive test or there is a history of a previously positive test, continue on with this portion of the form and submit BOTH pages.

POSTIVE TB SCREENING

Part III. STUDENT TB SYMPTOM SURVEY

Students with a previously positive, or newly positive TB skin test or IGRA must complete an annual questionnaire. Complete the following NOW. Then, a year from now, submit your responses through the link on the HSIP website.

Do you currently have any of the following symptoms/complaints? (Check No or Yes to each question; explain any Yes answers):

<table>
<thead>
<tr>
<th>Symptom</th>
<th>No</th>
<th>Yes (explain):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cough lasting greater than 3 weeks?</td>
<td>☐</td>
<td>□ Yes (explain):</td>
</tr>
<tr>
<td>Fever?</td>
<td>☐</td>
<td>□ Yes (explain):</td>
</tr>
<tr>
<td>Night Sweats?</td>
<td>☐</td>
<td>□ Yes (explain):</td>
</tr>
<tr>
<td>Unexplained Weight loss?</td>
<td>☐</td>
<td>□ Yes (explain):</td>
</tr>
<tr>
<td>Unexplained loss of appetite?</td>
<td>☐</td>
<td>□ Yes (explain):</td>
</tr>
<tr>
<td>Weakness/Fatigue?</td>
<td>☐</td>
<td>□ Yes (explain):</td>
</tr>
<tr>
<td>Bloody sputum?</td>
<td>☐</td>
<td>□ Yes (explain):</td>
</tr>
<tr>
<td>Chest Pain?</td>
<td>☐</td>
<td>□ Yes (explain):</td>
</tr>
</tbody>
</table>

Required: Student Signature ___________________________ Date questionnaire completed ____________

Part IV. DOCUMENTATION OF POSITIVE TB SCREENING: To be completed ONLY by Health Care Provider (HCP)

This section of the form should not be signed by student, parent, or spouse.

Instructions for HCPs completing this section: Please initial each section you are authenticating. A chest x-ray report or IGRA result must be submitted if indicated. Your signature and credentials are requested at the end of this form. All sections must be completed per instructions for BSN program acceptance.

POSITIVE TB SCREENING: If student has had a positive TB skin test (greater than or equal to 10mm) or positive IGRA in the past another test is unnecessary. However, we need the date and result of the positive test. Provider verification of (verbal) history is acceptable if documentation of a prior positive PPD is not available. Lab Report must be attached for a positive IGRA. A chest x-ray report must be submitted for any student identified as having a positive PPD or IGRA. The x-ray must be on or after 6/1/2015 unless you can provide the dates of a course of completed prophylactic treatment. Provider verification of treatment history is acceptable.

<table>
<thead>
<tr>
<th>PPD Placed:</th>
<th>Date Read:</th>
<th>Result:</th>
<th>HCP’s initials:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mo Day Yr</td>
<td>Mo Day Yr</td>
<td>mm</td>
<td></td>
</tr>
</tbody>
</table>

(greater than or equal to 10 mm is Positive)

OR

Date of Positive IGRA: ___________________________ (LAB REPORT MUST BE SUBMITTED WITH THIS FORM)

If positive PPD/IGRA: CXR after 6/1/2015 required (older CXR only okay if prophylactic treatment has been completed)

Date of CXR: ___________________________ Submit copy of the chest x-ray report. Do not send actual film.

PROPHYLACTIC TREATMENT INFORMATION:
Provider verification of (verbal) treatment history is acceptable if documentation is unavailable.

Rx/Medication Type: ___________________________

<table>
<thead>
<tr>
<th>Date Started:</th>
<th>Date Ended:</th>
<th>Length of Treatment:</th>
<th>HCP’s initials:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mo Day Yr</td>
<td>Mo Day Yr</td>
<td>Months</td>
<td></td>
</tr>
</tbody>
</table>
Tuberculosis Screening Form for Heritage University BSN Students 2015-2016

HEALTH CARE PROVIDER INFORMATION
NOTE: This section must be completed by HCP (MD, DO, NP, PA, RN or other appropriate designee) for authentication. Not to be completed by student or relative.

I certify the accuracy of the dates and other information on this form:

HCP’s Signature

Date

HCP’s name printed/stamp of facility: ____________________________ Phone number: ____________________

Return by PDF attachment to Sanchez_m1@heritage.edu 04/25/15