SCF Nursing Programs have made arrangements with the vendor Certified Background to enable students to track, access, and maintain immunization and compliance records throughout their academic program. This web based database allows students to access their immunization and compliance records from anywhere web access is available and gives the ability to update and download compliance with these requirements conveniently. This system also automatically notifies students when an immunization or compliance item is expiring and new material is required so that records can be updated as required.

Many required items do expire each year and need to be renewed on an annual basis. It is important to follow up with any notifications received from Certified Background regarding any compliance or immunization items that are expiring or have not yet been completed. Failure to provide the required material by the expiration date will show the record as "non-compliant" and the individual’s record will be flagged for review by program administration.

Every few weeks, program administrators review the database to identify student records which are flagged as "non-compliant" in the system.

Remaining in compliance is a professional obligation and strictly enforced by the nursing administration. Appointments for expired tests can be made in any location by inputting the local zip code. (Vacations are not an excuse for non-compliance).

Compliance with all required items must be maintained in order to be eligible to progress academically. Failure to comply with requested action items will result in the following actions:

- Registration hold placed on the student account which would impact the ability to progress academically until all items are completed.
- Withdrawal from clinical rotation.
- Unsatisfactory clinical evaluation.

I understand I must remain in compliance with all clinical requirements in order to continue in the nursing program.

Student Name__________________________________________     Date___________________________________

Please print

Signature ________________________________
**Student Immunization Record FORM A**

State College of Florida – Associate Degree Nursing

Mandatory for all clinical rotations, all students require documented proof of immunizations and health screenings for communicable disease. Proof includes this competed form by the student, which is verified, reviewed, and signed by a licensed health care professional. All items must be uploaded into your Certified Background webpage by **December 1st**.

Titors may be drawn instead of vaccinations. An antibody titer is a laboratory test that measures the level of antibodies in a blood sample. Your health care provider may check your antibody titer to determine if you had an infection in the past (for example, chickenpox) or to decide which immunizations you need.

<table>
<thead>
<tr>
<th>Student Name (print)</th>
<th>G00</th>
<th>Date of Birth</th>
<th>Telephone (Home)</th>
<th>Cell</th>
<th>Work</th>
</tr>
</thead>
</table>

**Measles, Mumps, Rubella (MMR) 2 doses or a positive titer**

<table>
<thead>
<tr>
<th>Date of 1st Immunization</th>
<th>2nd Immunization</th>
<th>OR Titer Result</th>
</tr>
</thead>
</table>

**DPT - primary series administered?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of last Td booster</th>
<th></th>
</tr>
</thead>
</table>

**TDAP – one time vaccine required**

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
</table>

**Varicella Vaccines (Chickenpox)** two (2) doses of Varivax vaccine are required OR MUST HAVE POSITIVE TITER,

(1) | (2) |

<table>
<thead>
<tr>
<th>Date of titer</th>
<th>Result (numeric lab level)</th>
</tr>
</thead>
</table>

**Hepatitis B Immunization: Series of 3 vaccine and titer required or signed declination form required** (last page)

<table>
<thead>
<tr>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
</tr>
</thead>
</table>

2nd dose is to be given one (1) month after the 1st dose. 3rd dose is to be given at least five (5) months after the 2nd dose. Titer required two (2) months after 3rd dose.

Hepatitis B Immune Titer (HBS antibody) result:

<table>
<thead>
<tr>
<th>Date of test</th>
</tr>
</thead>
</table>

Repeat series if Titer is negative or equivocal.
ANNUAL REQUIREMENTS FORM A Continued

TUBERCULOSIS SCREENING

Tuberculosis Screening: PPD (Mantoux) test is required annually. No Tine Test. Must be read by a health care professional. A negative QuantiFERON – TB Gold Test is also acceptable.

History of BCG? ☐ Yes, When __________ No ☐ (PPD recommended unless BCG administered in past 2 years).

2 step PPD required if student has not had a prior T.B. Skin Test (verbalized by student).

Date Administered ___________/_________/_________ Date Read ___________/_________/_________ Result ____________ in mm.

Date Administered ___________/_________/_________ Date Read ___________/_________/_________ Result ____________ in mm.

If positive ppd (> 10 mm) induration, was follow-up medical evaluation provided? ☐ Yes ☐ No
Was prophylaxis medication prescribed? ☐ Yes ☐ No Does student have symptoms or exposure to TB? ☐ Yes ☐ No

The QuantiFERON®-TB Gold test (QFT-G) is a whole-blood test for use as an aid in diagnosing Mycobacterium tuberculosis infection, including latent tuberculosis infection (LTBI) and tuberculosis (TB) disease. This test was approved by the U.S. Food and Drug Administration (FDA) in 2005. http://www.cdc.gov/tb

Date of test_________________________ Result _____________________

Chest X-ray required only if indicated by positive TST or QFT - G

Chest X-Ray Result________________________________________ Date of Chest X-Ray________________________

Chest x-ray every 5 years

Annual TB Symptom Review for previous + reactors only. Check if you have the following signs or symptoms
Do you have any of the following?
Cough (duration of 3 wks or more) yes _____ no ____ Night Sweats yes ____ no ____ Chest Pain yes ____ no ____
Appetite loss yes ____ no ____ Hemoptysis (coughing up blood) yes ____ no ____ Weight loss yes ____ no ____
Fever yes ____ no ____ Fatigue yes ____ no ____ Chills yes ____ no ______
Negative result of the QFT-G (QuantiFERON® - TB Gold Test) Date:_________________ Date_________________

_____________________________ ______________________
Signature of Student Date

Seasonal Influenza Vaccine required by October 1 annually.
Influenza vaccine Year 1 Date:_______/____/_______ Influenza vaccine Year 2 Date:_______/____/_______

OR declination form uploaded into Certified Background annually (Last page)

Healthcare Provider

I hereby certify that I have reviewed the student's vaccination/immunization form and performed required testing.

Name_________________________________________ License Number ________________________________

Practice Address _______________________________ Telephone______________________________

Signature_____________________________________ Date______________________________

This form and all laboratory test results must be uploaded into Certified Background in the Immunization section.

Revised 9/29/2012