

Nursing Sciences Immunization & Health Summary Form

Gwinnett Technical College-Lawrenceville-Alpharetta Campuses-5150 Sugar Loaf Parkway Lawrenceville

Last Name:		First Name:		DOB: Last 4 SS#	
Program:		Student ID:			
Enrollment Date:		Phone Number:			

RELEASE OF INFORMATION (TO BE SIGNED BY ALL STUDENTS)

I am a student at Gwinnett Technical College (GTC) and I authorize GTC to release a copy of this form to clinical facilities as necessary for my participation in clinical rotations.

STUDENT SIGNATURE: _____ **DATE:** _____

Immunization Summary-Attach Documentation of ALL Vaccinations or Titters. (IF BORN BEFORE 1957, go to OPTION 2)

Option1	Vaccine	Date	
MMR -2 doses of MMR vaccine Date is AFTER 1970	MMR Dose #1 (received immunization 12 months of age or later (and)	____ / ____ / ____	
	MMR Dose #2 (received 2 nd MMR at least 30days after Dose 1)	____ / ____ / ____	
Option 2	Vaccine or Laboratory Test	Date	
Measles -2 doses of vaccine or positive serology	Measles Vaccine Dose #1	____ / ____ / ____	<input type="checkbox"/> Documentation attached
	Measles Vaccine Dose #2 (or)	____ / ____ / ____	
	Laboratory Test (IgG, antibodies, titer) Circle 1: Reactive or Nonreactive	____ / ____ / ____	
Mumps -2 doses of vaccine or positive serology	Mumps Vaccine Dose #1	____ / ____ / ____	<input type="checkbox"/> Documentation attached
	Mumps Vaccine Dose #2 (or)	____ / ____ / ____	
	Laboratory Test (IgG, antibodies, titer) Circle 1: Reactive or Nonreactive	____ / ____ / ____	
Rubella -1 dose of vaccine or positive serology	Rubella Vaccine (or)	____ / ____ / ____	<input type="checkbox"/> Documentation attached
	Laboratory Test (IgG, antibodies, titer) Circle 1: Reactive or Nonreactive	____ / ____ / ____	

ALL STUDENTS MUST HAVE THESE VACCINES COMPLETED – HepB, Tdap, TB, Varicella, MMR, & Influenza

Primary HepB Series (And/or -depending on the clinical site) Laboratory Test	Date		
	Hepatitis B Vaccine Dose #1	____ / ____ / ____	
	Hepatitis B Vaccine Dose #2 (1 month after 1 st dose)	____ / ____ / ____	
	Hepatitis B Vaccine Dose #3 (6 months after 1 st dose) (or)	____ / ____ / ____	
	Laboratory Test (IgG, antibodies, titer)	____ / ____ / ____	<input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Documentation Attached
If Tdap is more than 10yrs ago, need a booster.	Tdap (Tetanus, Diphtheria, Pertussis)	____ / ____ / ____	<input type="checkbox"/> Documentation attached
Tuberculin or PPD Some clinical sites require a 2-step test-PPD Some facilities will not accept a PPD, only Titer	Tuberculin (TB) Skin Test or PPD Date Given	1 st ____ / ____ / ____	Positive _____ mm Negative _____ mm
	Tuberculin (TB) Skin Test or PPD Date Read	____ / ____ / ____	
	Tuberculin (TB) Skin Test or PPD Date Given	2 nd ____ / ____ / ____	Positive _____ mm Negative _____ mm
	Tuberculin (TB) Skin Test or PPD Date Read	____ / ____ / ____	
	Chest X-ray (if needed-PPD is positive)	____ / ____ / ____	Result Negative _____ Positive _____ <input type="checkbox"/> Documentation Attached
	T-Spot or QuantiFERON	____ / ____ / ____	Negative _____ Positive _____ <input type="checkbox"/> Documentation Attached
Varicella History is no longer accepted-ADN	Varicella (Chickenpox) vaccine	____ / ____ / ____	Disease ____ / ____ / ____
	Laboratory Test (IgG, antibodies, titer)	____ / ____ / ____	<input type="checkbox"/> Documentation attached

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	STUDENT NAME:		
Influenza vaccine	Sept/Oct	____/____/____	<input type="checkbox"/> Documentation attached

COVID-19-VACCINE

Moderna & Pfizer vaccines proof of 2 doses of vaccination		Date	
	Moderna	1 st ____/____/____	2 nd ____/____/____
	Pfizer	1 st ____/____/____	2 nd ____/____/____
	Johnson & Johnson vaccine proof of 1 dose of the vaccination only	Johnson & Johnson	1 st ____/____/____

HEPATITIS B WAIVER

I have been informed and understand the risks and benefits of the Hepatitis B vaccine and elect not to receive the vaccine.

Student signature: _____ Date signed: ____/____/____

RELIGIOUS EXEMPTION

I affirm that required immunizations are in conflict with my religious beliefs. I understand that I am subject to exclusion from clinical participation in the event of an outbreak of a disease for which immunization is required.

Student signature: _____ Date signed: ____/____/____

OTHER EXEMPTIONS
☐ This student is exempt from the above immunizations on the grounds of medical contraindication.
☐ This student is temporarily exempt from the above immunization until ____/____/____

☐ Documentation attached

Technical Standards/Demands

Are you aware of the "Technical Standards/Demands" for the program of study? Yes_____

Are you able to meet the technical standards...such as standing, bending, walking, and lifting per day/hours?

_____ I am **able** to meet the technical demands

_____ I am **not able** to meet the technical demands

Signature of Student: _____ Date: _____

[Please review the Technical Standards entire document]

It is the student's responsibility to keep their immunizations up-to-date. Immunization requirements are subject to change as per clinical guidelines.

IMMUNIZATION & HEALTH SUMMARY REVIEWED BY AND STATUS CERTIFIED BY:

I have reviewed the immunizations, hepatitis waiver, religious/other exception, and technical standards with the student as noted above. The information on this physical form is accurate and complete to the best of my knowledge.

Signature of Physician/Assistant/ NP _____	Date: _____
Print Name _____	
Name/Address/Phone#- of Health Care Facility: _____	

PLEASE PRINT CLEARLY – THIS INFORMATION MUST BE LEGIBLE!

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