

Nova Southeastern University Health Professions Division
Mandatory Immunization Form

A HEALTHCARE PROVIDER'S SIGNATURE IS REQUIRED ON BOTH PAGES ONE AND TWO

Student's Name: Jessica Stone Date of Birth: 03/23/93
College Program: Doctor of Optometry Phone Number: 334-398-2311

THE ANTIBODY TITERS FOR THE VACCINES LISTED IN SECTION A MUST BE ATTACHED

SECTION A

MEASLES, MUMPS, and RUBELLA

Students must have received two doses of MMR vaccine or have serologic immunity to measles, mumps and rubella.

MMR vaccine: dose #1 6/24/1994 dose #2 5/22/1998
or
Date of Measles titer / / *lab result must be attached Immune: Yes No
Date of Mumps titer / / *lab result must be attached Immune: Yes No
Date of Rubella titer / / *lab result must be attached Immune: Yes No

VARICELLA

Varicella vaccine: First dose: 11/13/1996 and Second dose: / /
or
Varicella IgG Antibody titer: / / *lab result must be attached Immune: Yes No

HEPATITIS B

Serologic testing is required for hepatitis B surface antibody. Serologic immunity should be tested 1-2 months after completion of the three dose hepatitis B vaccine series.

Hepatitis B Vaccines: dose #1 3/23/1993 dose #2 4/25/1993 dose #3 1/13/1994
and Dose #4 Booster 7-18-17
Date of Hep B Surface Antibody 7/7/17 *lab result must be attached Immune: Yes No ✓

SECTION B

TETANUS-DIPHTHERIA

Tetanus / Diphtheria / Pertussis (Tdap)**: / / Tetanus / Diphtheria (Td): / /
**Due to the increased risk of pertussis in healthcare settings the Advisory Committee on Immunization Practices / CDC recommends "Healthcare personnel should receive a single dose of Tdap as soon as feasible if they have not previously received Tdap and regardless of the time since last Td dose." After receiving Tdap, routine booster shots against tetanus and diphtheria should follow existing guidelines every 10 years.

pending

I certify that the information above is complete and accurate to the best of my knowledge:

Healthcare Provider Printed Name Amy Morris RN-BC Date 7/7/17
Healthcare Provider Signature Amy Morris RN-BC

**Nova Southeastern University Health Professions Division
Certificate of Physical Examination**

Based on review of the patient's medical history, immunization records, and physical examination performed and on file in my office this date 7-7-17, it is my impression that

Name of student Jessica Stone Social Security Number _____

College Program _____ Date of Birth 3/23/1993

has received the required immunizations and that he/she meets the physical requirements for attendance at Nova Southeastern University Health Professions Division.

I certify that the information herein is complete and accurate to the best of my knowledge.

Healthcare Provider Printed Name Carol Stewart, MD Date 7-7-17

Healthcare Provider Signature [Signature] MANDATORY Office or Healthcare Provider Stamp:

Office Phone Number 334-244-3281

Office Address _____

**Upload completed form prior to start of program to:
<https://www.castlebranch.com/>**