TEXAS A&M UNIVERSITY – COMMERCE
Nursing Department
Immunization Information Sheet

Students are expected to provide proof of receiving vaccines and titers (blood work). See examples of correct documentation.

You should begin working to complete the requirements on this form as soon as you are accepted into the Nursing program.

As you begin obtaining your vaccines and blood work, make a copy of the forms you receive, then mail or hand deliver to the Nursing Department. Make sure that you have your return address on the envelope. Do not email the forms— you must provide a hard copy.

Send your forms to the following address:

Texas A&M University – Commerce
Nursing Department
ATTN: Cheryl McKenna, MSN, RN
P.O. Box 3011
Commerce, TX, 75429

**Tetanus, Diphtheria, Pertussis (Tdap)**- Obtain a Tdap vaccine (shot). Tdap vaccine is not the same as Dtap. Dtap is the children’s version. Tdap is the adult version;

**Measles, Mumps, Rubella (MMR) titers**- You will need to have blood drawn for these tests. The name of the test that must be ordered is: IgG quantitative titers for measles (rubeola), mumps, and rubella. If the quantitative titer value (number) is low and determined to be negative (non-immune) or as equivocal, you must receive two (2) doses of MMR vaccine, with the second dose administered 28 days after the first. A titer must be repeated for the low values 4-6 weeks after the 2nd vaccine (shot).

**Varicella (Chicken Pox)**- You will need to have blood drawn for this test. The name of the test that must be ordered is: IgG quantitative varicella titers. If the quantitative titer value (number) is low and determined to be negative (non-immune) or as equivocal, you must receive two (2) doses of varicella vaccine, with the second dose administered 28 days after the first. You are not required to repeat the titer. Proof of chicken pox disease is not accepted.

**Hepatitis B**- A 3-dose series of hepatitis B vaccine (shots) is required. The second dose should be administered 1 month after the first dose; the third dose should be given approximately 5 months after the second dose. Students who are unable to submit an immunization record but have received the series will need to submit laboratory evidence of immunity to the disease (quantitative antibody titer).

**Flu Shot**- A yearly flu shot is required. Flu vaccine is obtained in September each year.

**Tuberculin Skin Test (TST)**- You will need 2 TB skin tests. Obtain the first one; have the test read 48-72 hours after receiving it. Seven days later, obtain the 2nd test. Have it read 48-72 hours later. All TST documents must contain: the date administered, date read, results (e.g., negative), and millimeters of induration, even if that is zero (0). The signature of the person administering the test and the person reading the results are also required. Examples are provided on the following pages.
If a student has received BCG (a vaccine), the student must obtain a TB blood test called an IGRA (E.g. T-Spot or QFT).

A student who has or had a positive TST must have a clear (negative) chest x-ray report (no older than 2 years) from their healthcare provider. The student must also provide a copy of the positive test results from the healthcare provider. If you have had a positive TST, do not obtain any more TST. Students who have tested positive on a TST are required to complete the ‘Tuberculosis Symptoms Questionnaire’ yearly while enrolled in Texas A&M University-Commerce Nursing Program.

**New Vaccinations** – *For any new vaccination, documentation must include: name of agency where vaccine was obtained, student name, vaccine, dose, lot number, date of administration, site of administration, and initials/signature of individual administering vaccine.* This includes any vaccine administered at a clinic (including University Health Services), pharmacy, health department, or hospital.

**Records that are acceptable as proof of documentation:**
- Vaccine records from a physician's office, clinic, or health department; must be signed by the physician or the person who administered the vaccine; must include date of administration; example is Childhood Immunization Record (e.g., Shot Record)
- Official vaccine documentation form on agency letterhead

**Records that are NOT acceptable as proof of documentation:**
- A secondary source such as a university or high school transcript, Nursing Immunization Form, or Health Record
- A cash register receipt for a vaccination
Example #1- TB Skin Test Documentation

Student Health Services
Immunization Summary

Patient Name: Jane Doe
Patient Number: 123456789
DOB: 01/31/1988
Procedure: PPD
Date: 02/09/2015
Result: 0 mm

Details: Administration Record. Lot Number: 123456. Strength: 5 TU PER DOSE. Expiration date: 1/31/2016; Volume: 0.1 ML; Route: INTRADERMAL; Site: Left Forearm; Administered By: Raggedy Anne, RN; Administered: 02/09/2015 10:00 AM; Diagnosis: TUBERCULOSIS SCREENING V7.1.1; Recorded date: 02/09/15 10:15 AM; Date Read: 02/11/2015 1:13 PM; Result: 0 mm; Interpretation: Negative; Recorded by: Raggedy Annie, RN; Recorded Date: 02/11/2015 1:20 PM
Example #2- TB Skin Test Documentation

Dr Sally Ride, MD
1234 Elm Street
Commerce, TX, 75428

PPD Testing

Date Administered: 2/22/15 Name: Jane Doe

PPD Manufacturer: HG Pharmaceuticals
PPD Lot #: 123456
Expiration Date: Jan 31, 2016

Signature of person administering injection: Raggedy Anne

PPD Reading

Use metric tool to measure size of induration (raised area) across the widest area, NOT erythema (redness). Record in space below.

Date Read (48-72 hours after injection administered): 2/24/15

#mm induration: 0mm (negative)

Signature of valid reader: Raggedy Anne
**VACCINE ADMINISTRATION RECORD**

Vaccine administrator: Before administering any vaccines, make sure the person understands the risks and benefits of these vaccines and that their questions have been answered to their satisfaction. Make sure you give the patient an updated shot record card at every visit.

<table>
<thead>
<tr>
<th>Vaccine &amp; Route</th>
<th>Date Given (mo/day/yr)</th>
<th>Dose</th>
<th>Site Given (RA, LA, FY, IT)</th>
<th>Manufacturer</th>
<th>Lot Number</th>
<th>Exp. Date</th>
<th>Signature or Initials of Administrator</th>
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<tr>
<td>Influenza (IM)</td>
<td>02/07/2014</td>
<td>D5 1/2</td>
<td>L-5</td>
<td>Sanofi Pasteur</td>
<td>Y01819 AA</td>
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CONSENT FOR SERVICES and MEDICAL RECORDS INFORMATION

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet corresponding to the vaccine(s) that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize CVS/pharmacy ("CVS") to release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

HIPAA AUTHORIZATION: I voluntarily authorize and direct my health care provider at CVS/pharmacy ("CVS") to use and disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at CVS (standing order provider HINOJOSA, CAMILLE), my Primary Care Physician (KOGER, LINTON), my insurance plan, health systems and hospitals, and/or state or federal registries, where required, for purposes of treatment, payment or other health care operations (such as administration or quality assurance) during the term of this HIPAA Authorization ("Authorization"). This Authorization permits CVS to disclose only documents related to the vaccination(s) received today. This Authorization will remain in effect until my health information is disclosed to the recipient identified above. CVS cannot guarantee that any recipient will not redisclose my health information to a third party that may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such a refusal or revocation will not affect the commencement, continuation or quality of my treatment by CVS. I understand that this Authorization will remain in effect until the term of this Authorization expires as noted above or I provide a written notice of revocation to CVS at the address provided in the CVS Notice of Privacy Practices. The revocation will be effective immediately upon CVS receipt of my written notice, except that the revocation will not have any effect on any action taken by CVS in reliance on this Authorization before it received my written notice of revocation.

____________________________
[Signature]

Date: 9/19/14

Vaccine Administration Information:

Administration Date: 09/19/2014
Vaccine: AFLURIA 2014-2016 SYRINGE
Lot #: T57206
Exp. Date: 05/2015
Volume (mL): 0.50

Manufacturer: CSL BIOThERAPIE
Route: IM
Site: Right Deltoid

Morrison Timothy, RPh
Administering Immunizer Name & Title

Date VIS Given to Pt: 09/19/2014

[Signature]
Administering Immunizer Signature