HEALTH PROFESSIONS DIVISION
ASSOCIATE IN APPLIED SCEINCE – NURSING
Associate Degree Nursing Program Immunization Record

Name: ____________________________ TSC Student ID # ______________________

	Date	**Date**	**Date**	**Serologic**
MMR	#1	#2		
Varicella Vaccine	#1	#2	Illness	
Hepatitis B Vaccine	#1	#2	#3	
Tetanus (TD) (within last ten years)				
TDAP				
Meningococcal (age 21 or younger)				
TB Test (annual) CXR (if PPD positive every 5 years)				
Flu vaccine (seasonal time October - April)				

** All vaccines must be current and complete **prior to the first day of class**. No vaccines may expire in the middle of a semester.

Comments: ____

_________________________________ ____________________
Health Care Provider Signature Date

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Name and Address of Provider