Blackstone Valley Practical Nursing Program
Verification of Health Records Worksheet For HCP

Student Name: _____ Date: _____ Cohort: 2025-2027

All Health Requirements must be within 1 year prior to the start of the PN Program – August 1, 2024-August 1, 2025. See Health Requirements Column. Documentation must be submitted as evidence of Health Requirements, as needed.

Documents Required	Health Requirements		Results (Dates and Results)	√
Influenza (Flu)	1 dose of Flu Vaccine every Flu season or prior to start of the program	→	Flu Vaccine Date:	
Tdap (Tetanus, Diphtheria, Pertussis)	1 dose of Tdap vaccine within 10 years	→	Tdap Vaccine Date:	
MMR (Measles, Mumps, Rubella) – 2 vaccines 28 days apart OR titers for each.	Dose #1: #2:	OR	Measles Titer (Date & Results): Mumps Titer(Date & Results): Rubella Titer(Date & Results):	
Varicella (Chickenpox) - 2 vaccine greater than 4 weeks apart, titer or history of disease (HCP Note Needed)	Dose #1: #2: **OR** History of Disease (HCP Note)	OR	Varicella Titer(Date & Results):	
Hepatitis B- Series 2 or 3 and Hepatitis B Titer- Hepatitis B or Acknowledge for Non-Responder	**3-4 months to complete - preferred** 2 doses Heplisav-B formulation: 1) 1st dose Hep B 2) 1 month – 2nd dose – Hep B THEN 1-2 months after 2nd dose – need a Titer **9 Months to complete** 3 doses Engerix 1 X-B or Recombivax – HB formulation: 1) 1st dose Hep B 2) 1 month – 2nd dose – Hep B 3) 6 months – 3rd dose – Hep B THEN 1-2 months after 3rd dose – need a Titer **Hepatitis B Acknowledge for Non-Responder**	AND	Hepatitis B Titer(Date & Results):	
Meningococcal	1 dose for any full time or part time health science student before the age of 21 or younger.	→	Meningococcal Vaccine Date:	
Tuberculosis	1 negative IGA blood test (t-spot or QuantiFERON) within 1 year. **OR** History of Positive TB	→	TB Blood Test(Date & Results): **OR** Negative Chest X-Ray within past 2 years. **And** TB Blood Test(Date & Results)	
Covid – 19 Need copy of Covid card showing all Covid vaccinations and boosters	Moderna/Pfizer Dose #1: #2: **OR** Johnson & Johnson Dose #1:	AND	Covid Booster Date: **and/or** Covid Bivalent Date: **and /or** Covid Fall 2023 Novavax Booster Date:	

HCP Print Name: _____ HCP Signature: _____ Date: _____/_____/_____

Address: _____ Phone: _____/_____/_____