Texas Wesleyan
GRADUATE PROGRAMS OF NURSE ANESTHESIA

Immunization Summary

NAME:_____

To be completed by the student. Please provide proof of all vaccinations/titers. This includes copies of original records, lab/doctor's report or employer reports (excluding compliance reports). **All documents must be signed/stamp validated from a U.S. medical source.**

Student is subject to dismissal if documents are falsified.

	VACCINE DATE		*OR*		*TITER (Value & Range required)*	
Hepatitis A (2 doses)	**Dose 1**	**Dose 2**			**Value/Units**	***AND*** **Reference Range**
Hepatitis B (3 doses)	**Dose 1**	**Dose 2**	**Dose 3**		**Value/Units**	***AND*** **Reference Range**
Mumps/Measles/Rubella (2 doses)	**Dose 1**	**Dose 2**			**Value/Units**	***AND*** **Reference Range**
Varicella (2 doses OR titer)	**Dose 1**	**Dose 2**			**Value/Units**	***AND*** **Reference Range**
Documented history of Chickenpox will require Varicella titer *with* Value and Range						
TDAP - Tetanus/Diphtheria/Pertussis (every 10 years)	***Most Recent***					
PPD/TB Skin Test Screening (Annually)	***Most Recent***					
	Skin Test: Date & mm			***OR***	**Chest X-Ray: Full x-ray report (Most Recent)**	
	Date:	Result:			Date:	
	OR **QuantiFERON (Most Recent)**					
	Date:	Result:				
Flu Shot (Annually)	***Most Recent***					