NORTH IOWA AREA COMMUNITY COLLEGE
CERTIFIED NURSE AIDE COURSE
IMMUNIZATION RECORD

STUDENT LAST NAME: _____**FIRST NAME** _____
(Please Print)

DATE OF BIRTH:_____ **COURSE SECTION:** _____ **DATE:**_____

IMMUNIZATIONS AND TESTS

Clinical affiliations require that our students provide evidence of the following prior to beginning the clinical rotations.

1) **T**uberculin Test— 2 step PPD Skin Test by Mantoux (NOT TINE) is to be completed prior to start of class. A positive test requires chest x-ray and prophylactic treatment consideration. Dates of testing must be within 12 months of the last day of the desired Nurse Aide class. **A minimum of 7 days are needed between administration of TB test #1 and #2.**

2) Hepatitis B Vaccine series or the signed waiver (Waiver on back of the form).

This section is to be completed, SIGNED and dated by a licensed health care provider in the shaded area indicated below.

Two-Step Tuberculin Skin Test:

	Date Admin:	**Date Read:**	**Results: mm of induration**
# 1	_____ MM/DD/YY	_____ MM/DD/YY	_____
# 2	_____ MM/DD/YY	_____ MM/DD/YY	_____

***If Positive PPD, complete the following:**

Chest X-ray

_____ _____
MM/DD/YY *CXR Results

Copy of signed Chest x-ray and report required. Please attach to the form.

Is treatment plan indicated: Check one : ___No ___Yes I

If treatment plan is indicated please attach to this form.

.Hepatitis B:

#1 Date _____

#2 Date _____

#3 Date _____

Injections 2 and 3 must be reported when completed

2b. Date Waiver Signed: _____
(Waiver must be signed if series is not begun; otherwise series must be initiated.)

I certify this student has received TB testing, results as indicated above.

_____ _____ _____
Print name of Health Care Provider Signature of Health Care Provider Date

_____ _____ _____ (____)_____
Address of Health Care Provider City State Zip Phone