WAGNER COLLEGE

Evelyn L. Spiro School of Nursing

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VACCINATION STATUS
*REQUIRED ONCE ONLY

BS 15MONTH MS DNP

LAST NAME	FIRST NAME	Date of Birth	WAGNER ID
ADDRESS	CITY, STATE	ZIP	
GENDER IDENTITY Male Female Other	PHONE (cell)	Email	

DO NOT WRITE BELOW THIS LINE **DO NOT WRITE BELOW THIS LINE**

PART A: MMR/VARICELLA **DATE FORM COMPLETED_________**

	PROOF OF TWO DOSES		**OR**	**PROOF OF TITERS**	
MEASLES	Dose #1 Date	Dose #2 Date	**OR**	Date Drawn	Immune/Not Immune
MUMPS	Dose #1 Date	Dose #2 Date	**OR**	Date Drawn	Immune/Not Immune
RUBELLA	Dose #1 Date	Dose #2 Date	**OR**	Date Drawn	Immune/Not Immune
VARICELLA	Dose #1 Date	Dose #2 Date	**OR**	Date Drawn	Immune/Not Immune
IF NO PROOF OF VACCINES AND TITERS ARE NEGATIVE PT WILL REQUIRE VACCINATION:					
1ST DOSE DATE				PT TO RETURN ON	

PART B: HEPATITIS B

	PROOF OF THREE DOSES		**AND**	**PROOF OF TITERS**
Dose #1 Date	Dose #2 Date	Dose #3 Date		Date Drawn
IF NO PROOF OF VACCINES AND TITERS ARE NEGATIVE PT WILL REQUIRE VACCINATION:				
1ST DOSE DATE			PT TO RETURN ON:	
PATIENT IS A NON RESPONDER			**REFERAL TO SPECIALIST**	

PART C: TETANUS (WITHIN LAST 10 YEARS)

DATE GIVEN:	

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PART D: MENINGOCOCCAL VACCINE *** MUST BE WITHIN 5 YEARS***

Date of Meningococcal (ACWY-135) vaccine: ____________

OR

TO DECLINE (signature required):
I understand that during my clinical experience I may be exposed to potentially infectious materials and I may be at risk of acquiring meningitis infections
.
I decline the meningitis vaccination at this time. I have been informed and understand the possible risks of acquiring meningitis.

Student/Patient Signature: ______________________ Date:___________________

PART E: SEROGROUP B MENINGOCOCCAL VACCINE

Date of Meningitis Serogroup B (Men B) Vaccine: __________________ SECOND DOSE DUE ON:________________

N/A due to age- 24 years or older ☐

OR

TO DECLINE (signature required):
I understand that during my clinical experience I may be exposed to potentially infectious materials and I may be at risk of acquiring meningitis infections
.
I decline the Meningitis B vaccination at this time. I have been informed and understand the possible risks of acquiring meningitis.

Student/Patient Signature: ______________________ Date:___________________

PROVIDER NAME:	STAMP and SIGNATURE
PHONE NUMBER:	