Cumulative Immunization Record
SWOSU Nursing Program

NAME: ____
(Please Print) **Last** **First** **Middle**

DOB: ______________________ **STUDENT ID:** ______________________
month/day/year

Immunization	**Date**	**Signature/Title/Facility** **(ALL THREE REQUIRED)** **(may attach copy of original immunization form)**

MUST BE COMPLETED BY JUNE 30th

 # 1 Measles/Mumps/Rubella ______________ ______________________
(after 1st birthday)

 # 2 Measles/Mumps/Rubella ______________ ______________________
(at least 1 month after 1st dose)

FIRST 2 DOESES BY JUNE 30th: THIRD BY NOVEMBER 30th

#1 Hepatitis B ______________ ______________________

#2 Hepatitis B ______________ ______________________
(Due 1 month after 1st injection)

 # 3 Hepatitis B ______________ ______________________
(Due 4 months after 1st injection and 2 months after 2nd injection)

MUST BE COMPLETED BY JUNE 30th

#1 Varicella ______________ ______________________

#2 Varicella
(Due 4-6 weeks after 1st injection) ______________ ______________________
OR
Positive Varicella Titer ______________ ______________________
OR
Documented History of Chickenpox ______________ ______________________

MUST BE COMPLETED BY JUNE 30th

NOTE: Booster TB test is required if this is your 1st TB test or if it has been > 1 year since your last test.

TB Skin Testing (completed within the last year)
Date given: ______________________
Date Read: ______________________
Results: ______________________
Signature/Title: ______________________

Booster (1-2 weeks after 1st test)
Date given: ______________________
Date Read: ______________________
Results: ______________________
Signature/Title: ______________________

Note: Students who have tested positive must submit CXR results, documentation of treatment received and complete an annual sign/symptoms questionnaire in SHS.

Yearly TB Skin Testing (updated annually while in school)
Date given: ______________________
Date Read: ______________________
Results: ______________________
Signature/Title: ______________________

Date given: ______________________
Date Read: ______________________
Results: ______________________
Signature/Title: ______________________

Date given: ______________________
Date Read: ______________________
Results: ______________________
Signature/Title: ______________________

Date given: ______________________
Date Read: ______________________
Results: ______________________
Signature/Title: ______________________

MUST BE UPDATED ANNUALLY (Copy of current CPR card must be on file in SHS)

CPR Certification 1st Year ______________ 2nd year ______________
Date Completed Date Completed

SEND COMPLETED FORM TO: STUDENT HEALTH SERVICES (SHS) 100 CAMPUS DRIVE WEATHERFORD, OK 73096 or Fax (580) 774-7121