Montachusett Regional Vocational Technical School
Practical Nursing Program
Student Required Immunization / TB Testing Record

Program Year: 2027 – 2028

Name: _____ DOB _____

REQUIRED DOCUMENTATION (Please check off and enter dates. Provider signature required.)

✓	REQUIREMENTS	DOCUMENTATION	DATES
	Measles, Mumps, Rubella: 2 MMR vaccines **or** documentation of positive titers.	**MMR #1:**	Enter Date
		MMR #2:	Enter Date
		MMR Titer:	Enter Date
	Varicella (Chicken Pox): 2 Varicella vaccines, **or** proof of illness, **or** positive titer	**Varicella #1:**	Enter Date
		Varicella #2:	Enter Date
		Date of Illness:	Enter Date
		Varicella Titer:	Enter Date
	Hepatitis B: 2 doses of Heplisav **or** 3 doses of Engerix-B, **or** positive titer, **or** signed declination	**Hep B #1:**	Enter Date
		Hep B #2:	Enter Date
		Hep B #3:	Enter Date
		Hep B Titer:	Enter Date
		Hep B Declination:	Enter Date
	Tuberculosis (TST) (PPD) or IGRA (T-Spot, QuantiFERON): Two step negative skin testing within six months **or** IGRA testing within one year. If prior history of positive TST, must provide completed and reviewed TB Symptom Questionnaire **and** record of negative chest x-ray within two years.	**Negative TST Step #1:**	Enter Date
		Negative TST Step #2:	Enter Date
		Negative IGRA Test Result:	Enter Date
		Negative Chest X-ray:	Enter Date
		Symptom Questionnaire:	Enter Date
	Tetanus, Diptheria, Pertusis (TDaP): 1 dose of TDaP **or** Td vaccine within 10 years	**TDaP Vaccine:**	Enter Date
		Td Vaccine:	Enter Date
	Meningococcal (16-21 years of age): 1 dose	**Meningococcal:**	Enter Date
	Influenza (Seasonal): Influenza vaccine within current flu season **or** signed exemption / declination form.	**Flu vaccine:**	Enter Date
		Flu declination:	Enter Date
	COVID Vaccines: COVID vaccines **or** exemption / declination as allowed per clinical facility requirements.	**COVID #1:**	Enter Date
		COVID #2:	Enter Date
		Updated COVID Booster:	Enter Date
		COVID Declination:	Enter Date

Documentation of immunization and titers have been verified by the provider and proof of lab results have been provided. Negative titers have been reviewed by provider for booster doses, if indicated.

_____ _____

Provider Signature / Date: Provider Printed Name: