Shawsheen Valley School of Practical Nursing

THIS PAGE MUST BE COMPLETED BY LICENSED HEALTHCARE PROVIDER

(Last Name) (First Name) (Middle) (DOB)

Verified by:

Postsecondary Immunizations Requirements

	Date
Influenza: After 9/1/2024	
Tdap: within 10 years of admission	
MMR#1	
MMR#2	
OR	
MMR titer: please include results	
Hepatitis B #1	
Hepatitis B #2	
Hepatitis B #3	
OR	
Heplisav-B #1	
Heplisav-B #2	
Hepatitis B titer: please give titer results	
If negative,	
Hepatitis B series	
Documented /If negative waiver signed	
Varicella #1	
Varicella #2	
OR	
Varicella Titer: please include results	
Meningococcal vaccine	
Under age 21	
QuantiFERON Gold blood test result	
COVID Vaccine #1	
COVID Vaccine #2	
COVID Booster	

By signing below, I find her/him free of any health impairment which is of potential risk to students, patients, faculty, and other personnel and which might interfere with the safe performance of her/his nursing student responsibilities, with or without reasonable accommodation. Habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances that may alter the individual's behavior has been considered in this evaluation.

Signature* of Examining Healthcare Provider:

(***Stamp is NOT acceptable in place of signature**)

Signature: _____

Date: _____

Stamp, copy of letterhead, or business card may be used for the following required information:

Print or type Name: _____

Office or Agency: _____

Address: _____

Telephone number: _____

STUDENT: Please retain a copy of this document for your records.