

**UNIVERSITY OF WEST FLORIDA B.S.N. PROGRAM APPLICATION**

**Immunization Form**

Rev. 5/11

**THIS FORM IS REQUIRED WITH NURSING APPLICATION – ALL IMMUNIZATIONS ARE REQUIRED**

Name _____	DOB _____	UWF ID _____
Local Address _____		Phone No _____

Required Immunization/Titer	Immunization Date(s) / Titer Results (WAIVERS/EXEMPTIONS CANNOT BE USED)
Hepatitis B (Series of 3) <i>Series must be started before you submit your application</i>	1) _____ 2) _____ 3) _____
Hepatitis B Titer/Results	Date of titer _____ Results _____
Measles, Mumps, Rubella (MMR) – series of 2 OR MMR Titer/Results	1) _____ 2) _____ Date of titer _____ Results _____
Meningitis	Date: _____
Varicella (series of 2) <i>Series must be started before submission of application</i> OR Varicella Titer/Results	<i>Please note: history of varicella disease is no longer sufficient.</i> 1) _____ 2) _____ Date of titer _____ Results _____
Tetanus Toxoid Booster	Date _____ (must be within last 10 years)
TB Skin Test (must be within last 12 months)	Date _____ Results: Negative _____ Positive _____ If positive, chest x-ray date: _____ Results: _____ Treatment (if indicated) _____

**HEALTHCARE PROVIDERS please note: both Hep B series AND titer results are required; history of varicella disease is no longer sufficient; must have varicella series OR titer results.**

Date \_\_\_\_\_ Provider Signature \_\_\_\_\_

Provider Name (printed) \_\_\_\_\_ License No./State \_\_\_\_\_

Licensed as (check one) M.D. \_\_\_\_\_ D.O. \_\_\_\_\_ Physician’s Assistant \_\_\_\_\_ ARNP \_\_\_\_\_

**APPLICANT: KEEP A COPY OF THIS COMPLETED IMMUNIZATION FORM FOR YOUR RECORDS.  
YOU WILL NEED IT LATER IF ACCEPTED INTO THE NURSING PROGRAM!  
We will NOT provide you with the copy you submit with your nursing application!  
*ALL IMMUNIZATIONS ARE REQUIRED. Titer results may take several weeks. Plan accordingly!***