GROSSMONT COLLEGE HEALTH PROFESSIONS
IMMUNIZATION REQUIREMENTS

To be cleared for the Grossmont College Nursing Program each vaccination and/or test, no matter what form being submitted to the program office, must have a signature and stamp from one of the following Healthcare Professionals completing the immunizations/test or transcribing information onto the form: Physician, Physician Assistant, Nurse Practitioner, Registered Nurse, or Grossmont College Health Services Nurse.

NAME: _____ **STUDENT ID#**: _____
Last First

MMR (Measles, Mumps, Rubella)

Must include 2 vaccinations **or** a test for seropositivity (proof of immunity)

Date #1: _____ (todays date) _____ Signature

Date #2: _____ (1 mo. following date #1) _____ Signature

Seropositivity
If known past history of Measles, Mumps or Rubella.

S. Date: _____ ☐ positive ☐negative _____ Signature

If born *before* January 1, 1957 only 1 dose of MMR or seropositivity is required.

STAMP

Hepatitis B

Must include 3 vaccinations **and** a test for seropositivity (proof of immunity).

Date #1: _____ (todays date) _____ Signature

Date #2: _____ (1 mo. following date #1) _____ Signature

All Health Professions students must complete the test for seropositivity.

Date #3: _____ (5 mo. following date #2) _____ Signature

Seropositivity-
If known past history of the Hep B infection and/or to verify immunity to Hep B.

S. Date: _____ (1 mo. following date #3) _____ Signature
☐ positive ☐*negative

HepB Surface Antibody, Quantitative (QT) **only**. (Qualitative(QL) results are not acceptable)

*If negative, additional booster and/or series plus immunity test required

Post-vaccination testing must be done 1 month after last dose of vaccine.

STAMP

Tetanus/ Diptheria and Acellular Pertussis (TDAP)

Date #1: _____ _____ Signature

Must be given 2005 or after.

STAMP

Varicella (Chickenpox)

Must include 2 vaccinations **or** test for seropositivity

Date #1: _____ (todays date) _____ Signature

Date #2: _____ (1 mo. following date #1) _____ Signature

Seropositivity
If known past history of chickenpox infection or statement from physician verifying past history.

S. Date: _____ ☐ positive ☐negative _____ Signature

STAMP