KILGORE COLLEGE
EMPHASIS EXCELLENCE ★ 1935
LONGVIEW

Kilgore College Nurse Aide Program

Immunizations and Physical Exam

This form must be signed by a healthcare professional.
Attach proof of shots. Must have all shots turned in *before* the first class day.

Name: _____ Phone: _____

Address: _____ DOB: _____

*Proof attached	Required Immunizations	Date	Result
	1. **Tuberculosis (TB)**		
	Skin Test		
	OR Chest X-ray (good for 3 years)		
	2. **Flu Vaccine (2018-2019)**		
	3. **Bacterial Meningitis Vaccine (Students 30 and under only.)**		
	4. **Varicella (chickenpox)**		
	2 Vaccines (1 dose if given before age 13)	#1. _____ #2. _____	
	OR Serologic confirmation of immunity (Varivax Titer)		
	OR History –Varicella validated by health care professional		
	5. **Hepatitis B**		
	3dose series of Hepatitis B vaccination dose #1 – before the first class day dose #2 – one month after 1st shot dose #3 – at least 4 months after 1st shot	#1. _____ #2. _____ #3._____	
	6. **Hepatitis B >10 ml/IU titer required**—drawn approximately 1 month after dose #3 Students with an antibody titer <10 ml/IU for Hepatitis B have to be revaccinated		
	7. **Measles, Mumps, Rubella (MMR)**		
	2 Vaccine boosters (given after 15 months age, under age 18) 1 vaccine if over 18 years of age	#1. _____ #2. _____	
	OR Serologic confirmation of immunity		
	8. **Tetanus, Diphtheria, and Pertussis (Tdap) - within the last 10 years**		

**Acceptable evidence of vaccines*

Vaccine administered after 9/1/99 shall include month, day and year each vaccine administered

Documentation of vaccine that includes signature or stamp of physician/designee or public health personnel

An official immunization record generated from a state or local health authority such as a registry

A record received from school officials

A full medical release with no restrictions is required if student is pregnant.

Physical Exam

Please list or attach a list of medications currently being taken: _____If drugs for a physical condition—state whether applicant's physical condition is controlled on medication: _____If drugs for a mental condition—state whether applicant is mentally and/or emotionally stable on medication: _____

In your opinion, is this individual in suitable physical and mental condition to participate in direct patient care?

Yes _____ ***No**_____ If ***No**, explain _____

_____ _____

Signature of Healthcare professional (required) **Printed/Typed/Stamped name of healthcare professional**

_____ _____

Phone Address City State Zip