BATES TECHNICAL COLLEGE
Nursing Assistant Program
IMMUNIZATION ENTRANCE REQUIREMENTS

*Please note that all requirements must be signed by a LICENSED medical personnel, (LPN, RN, MD) or the student will not be admitted into the program. Please circle only that which applies under each immunization requirement. Please attach documentation for proof.

*TB Skin Test: Please circle which TB test you are providing. If a symptom check is required, signature is verification of a negative symptom check.
1. Two-Step if not tested in last 12 months.
New Positive TB Results
2. Follow up by healthcare provider including negative chest X-ray & negative symptom check. (may also need to complete health questionnaire for facilities).
History of Positive TB Results
3. Proof of chest X-ray (lifetime except if symptomatic) and submission of a negative symptom check within the last 12 months.
History of BCG Vaccine

*If administered concurrently, or shortly after, a live virus vaccine (such as varicella), a TB skin test may produce a false negative.

Date: ___________________________ Results: ___________________________
Signature (inc. discipline): ___________________________

*Hepatitis B: Please circle all that apply.
1. Proof of Positive Hep B Titer. OR
2. Proof of Series Completion.
3. If student provides a negative Titer, student must repeat series (student allowed in program while completing second series) and if student remains negative on Titer, they may sign a waiver.
4. Signed waiver (provided by Bates) if Series declined.

Hepatitis B: 
Date: ___________________________ Signature: ___________________________

*MMR: Please circle one.
1. Proof of vaccination (2doses).
   Date: ___________________________ Signature: ___________________________
   OR
2. Titer showing positive proof of: Rubella, Rubeola, and Mumps.
   Date: ___________________________ Signature: ___________________________

Tetanus: If vaccinated within the last 10 years.
Date: ___________________________ Signature: ___________________________

OR

Tdap: Required if immunized after 6/1/07

*If you have not had a tetanus vaccine within the last 10 years you will need the Tdap immunization

Date: ___________________________ Signature: ___________________________

*Varicella Titer: Please circle one.
1. Proof of + Varicella Titer.

Varicella: Date: ___________________________ Signature: ___________________________

*Flu Vaccine: Please circle one.
1. Proof of Vaccine.
2. Waiver (provided by Bates) signed if declined.

Flu Vaccine: Date: ___________________________ Signature: ___________________________
PRE-ENTRANCE MEDICAL RECORD

Name of Applicant: _________________________________________________

I have reviewed the above named individual’s health history and conducted a physical examination.

The student is under care for the following chronic condition(s) and/or is taking the following medication(s): This information is optional and confidential. ______________________________________________________________

______________________________________________________________

Date: ______________ Signature/Title: ________________________________

Print name/title: _________________________________________________

_________________________________________________________________

PRE-ENTRANCE DENTAL RECORD

Name of Applicant: _________________________________________________

I have examined the above named individual and he/she is aware of any dental care needs.

Date: ______________ Signature/Title: ________________________________

Print name/title: _________________________________________________

_________________________________________________________________