Advanced Certified Nursing Assistant

IOWA WESTERN

This form **MUST** be returned to:

Iowa Western
Continuing Health Education
Looft Hall, Room 121
2700 College Road
Council Bluffs IA 51503

TO BE COMPLETED BY THE STUDENT (Please print clearly)

Name: _____
Last First Middle

Address: _____
Street/P.O. Box

_____
City State Zip

Phone: _____ Email _____

Fall/Spring/Summer 20____

Citizen: ❒ US ❒ Other (Specify)_____

Student ID (SS#)

Date of Birth

Month Day Year

REQUIRED IMMUNIZATIONS

Must be completed and signed by your healthcare provider

MMR (Measles, Mumps, Rubella) (two doses required for students born in 1957 or later)

❒ a. Dose 1 given at age 12-15 months or later ..... #1 ___/___/_____ (M D Y)

Dose 2 given at age 4-6 or later, and at least one month after the first dose..... #2 ___/___/_____ (M D Y)

OR

❒ b. Laboratory/serologic evidence of immunity (*attach copy of lab report*)..... ___/___/_____ (M D Y)

Tuberculosis Screening

❒ a. **Tuberculin Skin Test:**

Date #1 given ___/___/_____Results_____ Date #1 read ___/____/_____Results_____

Date #2 given____/___/_____Results_____ Date #2 read____/____/____Results_____

❒ b. **Chest x-ray** (required if tuberculin skin test is positive) result: Normal _____ Abnormal _____

Date of chest x-ray ___/____/_____ *Attach copy of chest x-ray report*

Hepatitis B—Required for all students. (Three doses of vaccine or a positive Hepatitis B surface antibody)

❒ 3 dose Hepatitis B series

Date #1 ___/____/_____ #2 ___/____/_____ #3 ___/____/_____ **OR**

❒ 3 dose combined Hepatitis A and Hepatitis B series

Date #1 ___/____/_____ #2 ___/____/_____ #3 ___/____/_____ **OR**

❒ Laboratory/serologic evidence of immunity or prior infection (*attach copy of lab report*) ___/___/_____ (M D Y)

REQUIRED IMMUNIZATIONS **Must be completed and signed by your healthcare provider**

Varicella (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 years)

- ❒ History of Disease verified by undersigned clinician..... Disease date ___/____/_____ **OR**
- ❒ Laboratory/serologic evidence of immunity (attach copy lab report) ___/___/_____ M D Y
- ❒ 1 dose given at 12 months of age or later but before the student's 13th birthday. Date of shot ___/____/_____ **OR**
- ❒ 2 doses. Dose 1 given after student's 13th birthday. 2nd dose at least one month after first dose

  Date #1 ___/____/_____ Date #2 ___/____/_____

Tetanus-Diphtheria-Pertussis (Primary series with DTaP, DTP, DT, or Td, and booster with Td or Tdap in the last ten years). **If students have not had Tdap as an adult, they are required to get one dose**.

- ❒ Primary series of four doses with DTap, DTP, DT or Td

  Date #1 ___/____/_____ #2 ___/____/_____ #3 ___/____/_____ #4 ___/____/_____

- ❒ Booster: Tdap (preferred) ..... Date ___/____/_____

Covid Vaccination: Please Provide Copy of your Vaccination Card-**mandated for clinical**

Brand Given Date____/____/____ Date____/____/____ Booster____/____/____

Influenza Vaccination Date____/____/____

Healthcare Provider (Signature or stamp required)

Name (Print)_____ Signature_____

Address _____

City _____ State _____ Zip _____

Phone _____ Date _____