

WAGNER COLLEGE

Evelyn L. Spiro School of Nursing

VACCINATION STATUS
 *REQUIRED ONCE ONLY
 ACADEMIC YEAR 2023-2024

DATE: _____

Circle One: MS DNP

LAST NAME	FIRST NAME	Date of Birth	WAGNER ID
ADDRESS	CITY, STATE	ZIP	
GENDER IDENTITY <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	PHONE (cell)	Wagner email	

DO NOT WRITE BELOW THIS LINE

DO NOT WRITE BELOW THIS LINE

PART A: MMR/VARICELLA

DATE FORM COMPLETED _____

	PROOF OF TWO DOSES		OR	PROOF OF TITERS	
MMR	Dose #1 Date	Dose #2 Date	OR	Date Drawn	Immune/Not Immune
MEASLES	Dose #1 Date	Dose #2 Date	OR	Date Drawn	Immune/Not Immune
MUMPS	Dose #1 Date	Dose #2 Date	OR	Date Drawn	Immune/Not Immune
RUBELLA	Dose #1 Date	Dose #2 Date	OR	Date Drawn	Immune/Not Immune
VARICELLA	Dose #1 Date	Dose #2 Date	OR	Date Drawn	Immune/Not Immune
IF NO PROOF OF VACCINES AND TITERS ARE NEGATIVE PT WILL REQUIRE VACCINATION:					
1 ST DOSE DATE				PATIENT TO RETURN ON	

PART B: HEPATITIS B

	PROOF OF THREE DOSES		AND	PROOF OF TITERS
Dose #1 Date	Dose #2 Date	Dose #3 Date		Date Drawn
IF NO PROOF OF VACCINES AND TITERS ARE NEGATIVE PT WILL REQUIRE VACCINATION:				
1 ST DOSE DATE			PATIENT TO RETURN ON:	
<input type="checkbox"/> PATIENT IS A NON RESPONDER			<input type="checkbox"/> REFERRAL TO SPECIALIST	

PART C: TDAP (WITHIN LAST 10 YEARS)

DATE GIVEN:	
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PART D: MENINGOCOCCAL VACCINE

Date of Meningococcal (ACWY-135) vaccine: _____ **OR**

TO DECLINE (signature required):

I understand that during my clinical experience I may be exposed to potentially infectious materials and I may be at risk of acquiring meningitis infections

I decline the meningitis vaccination at this time. I have been informed and understand the possible risks of acquiring meningitis.

Student/Patient Signature: _____ Date: _____

PART E: SEROGROUP B MENINGOCOCCAL VACCINE

Date of Meningitis Serogroup B (Men B) Vaccine: _____ **SECOND DOSE DUE ON: _____**

N/A due to age- 24 years or older ☐

OR

TO DECLINE (signature required):

I understand that during my clinical experience I may be exposed to potentially infectious materials and I may be at risk of acquiring meningitis infections

I decline the Meningitis B vaccination at this time. I have been informed and understand the possible risks of acquiring meningitis.

Student/Patient Signature: _____ Date: _____

PROVIDER NAME:	STAMP and SIGNATURE
PHONE NUMBER:	