Covenant School of Nursing
1919 Frankford Ave
Lubbock, TX 79407

Covenant School of Nursing

What is the Immunization Verification Form? If an applicant is selected this allows our Employee Health Office to process tentatively accepted students more efficiently.

Where can I go to get this form filled out? It is the applicant's responsibility to contact their healthcare provider or a healthcare provider of their choice. Explain to them that you are applying to a nurse aid program and are required to have this form completed by a healthcare provider. The applicant must gather all their shot records and take to the healthcare provider of their choice. The healthcare provider will copy over the information you provide them.

To be completed and signed by a physician or other licensed Health Care Provider. Examples are a Registered Nurse, Nurse Practitioner or Physician that is licensed by the state and has a professional association to a health care facility.

What if I cannot get this form completed by the deadline? This form is a required document for the application process. If you are having difficulty getting this form completed, please email in a timely manner Katie Martin at katie.martin@covhs.org. If you are unable to get this form completed by the deadline, please check our website to apply for the next application cycle.

Where can I get a copy of my immunization records? Here are some recommendations as to where to look for your immunization/vaccine records.

Check with your medical provider/clinic and schools that you have attended.

Can I just turn in my shot record? No, this form is a required form for the application process.

What if I do not have any documentation of my shot records? If you have no documentation at all, you can have the serologic test/s (lab work) for those immunizations that you do not have documentation for or you may get the immunizations again.

Will additional documentation of immunizations be required if selected? No additional requirements will be required once the applicant is accepted.

If you have questions, please, email the Admission Officer Katie Martin at katie.martin@covhs.org

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Applicant Name: _____
DOB: _____
Last 4 of SS#: _____
Nurse Aide Program

To be completed by a Physician or Other Health Care Provider. Please do not sign the compliance form unless the named person has proper vaccines or immune test. Note: All vaccines administered after September 1, 1991 shall include the MM/DD/YY that each vaccine was given.

Immunization		Option #2	Obtain a Titer "blood draw" from Dr. Office showing "positive" for antibodies/immunity Note: if negative, a booster or vaccine is required.
Measles (Rubeola)*: Two doses of measles-containing vaccine on or after January 1, 1968.	Date#1_____ Date#2_____ **(mm/dd/yy)** At least 30 days apart	**OR** Serologic test positive for measles antibody	Date_____ **(mm/dd/yy)** Results_____
Mumps: One dose of mumps vaccine on or after January 1, 1957.	Date#1_____ Date#2_____ **(mm/dd/yy)**	**OR** Serologic test positive for mumps antibody	Date_____ **(mm/dd/yy)** Results_____
Rubella: One dose of rubella vaccine on or after the first birthday.	Date#1_____ **Combined MMR Vaccine is vaccine of choice if recipients are likely to be susceptible.** ****Must include date of test collection. ****	**OR** Serologic test positive for Rubella antibody	Date_____ **(mm/dd/yy)** Results_____
Varicella: Two doses of varicella vaccine. **History of Disease is not accepted. Must have Vaccine or Titer.**	Date#1_____ Date#2_____ **(mm/dd/yy)** Doses must be 30 day apart	**OR** Serologic test positive for Varicella antibody	Date_____ **(mm/dd/yy)** Results_____

IMPORTANT NOTICE TO APPLICANTS: Please be aware that all of our students are required to have completed the HEP B series before the start of school. If you have not yet begun to receive this series, **or if you will not have it completed before classes begin, you will not be eligible for admission. THIS IS A NON-NEGOTIABLE REQUIREMENT.**

Hepatitis B: (3 doses) "PreHevbrio only 2 does required" Date#1_____ Date#2_____ Date#3_____ **(mm/dd/yy)**	**OR**	Serology/Titer (lab work results) Date_____ **(mm/dd/yy)** Results_____ **Must include date of test collection and results; It is highly recommend that applicants complete the lab work.**

Note: An accelerated dosing schedule with Twinrix vaccine (Hepatitis A and Hepatitis B recombinant) may be an option to meet Texas DSHS requirements for Hepatitis B immunization.

Tdap (tetanus, diphtheria, pertussis"whooping cough")
One dose of Tdap within the last 10 years. Date_____
(mm/dd/yy)

Last TB screening Date_____
(mm/dd/yy)
Note: not required

Bacterial Meningitis: For those that are 22 years old or younger.	**MCV-4** Date_____ **(mm/dd/yy)** **OR**	**MPSV-4** Date_____ **(mm/dd/yy)**

To be completed and signed by a physician or other licensed Health Care Provider. Example a Registered Nurse, Nurse Practitioner or Physician that is licensed by the state and has a professional association to a health care facility. Signature:_____ Signature validates all information on this form. Date:	Name of Dr./Office:_____ Address:_____ City: _____State:_____ Phone:

TUBERCULOSIS SCREENING QUESTIONNAIRE

Providence St. Joseph Health

Name: _____ **Date of Birth:** _____ **Date** _____
Last First Middle

Dept: _____ **Home/Cell Phone #:** _____

☐**Caregiver/Applicant** ☐**Volunteer** ☐**Other:** _____

DO YOU CURRENTLY HAVE SYMPTOMS OF:		**If yes, please explain**
1. Persistent and/or productive cough for more than three weeks?	☐Yes ☐ No	
2. Cough for more than one week following confirmed TB exposure?	☐Yes ☐ No	☐N/A
3. Prolonged low grade fever associated with cough for more than 1 week?	☐Yes ☐ No	
4. Blood present in sputum?	☐Yes ☐ No	
5. Unexplained night sweats (unrelated to menopause)?	☐Yes ☐ No	
6. Unusual fatigue for more than two weeks?	☐Yes ☐ No	
7. Loss of appetite for more than two weeks?	☐Yes ☐ No	
8. Unexplained weight loss of five pounds or more?	☐Yes ☐ No	
CURRENT HEALTH STATUS:		**If yes, please explain**
9. Do you have an acute viral infection or febrile illness?	☐Yes ☐ No	
10. Have you had a live-virus vaccine in the past four weeks?	☐Yes ☐ No	
11. Are you on or planning to begin immunosuppressive therapy or treatment for: diabetes, human immunodeficiency virus (HIV) infection, organ transplant recipient, undergoing radiation therapy, chemotherapy, treatment with a TNF-alpha antagonist (e.g., Infliximab, etanercept, or other), chronic steroids (equivalent of prednisone >15 mg/day for >1 month) or other immunosuppression medication? (*)	☐Yes ☐ No	
HISTORY:		**If yes, please explain**
12. Have you lived or visited (more than one month) in a country with a high TB rate? (Any country other than the United States, Canada, Australia, New Zealand and those in northern Europe or Western Europe). (*)	☐Yes ☐ No	
13. Have you had unprotected close contact with someone who has had infectious TB disease in the past 12 months or since your last TB test? (*)	☐Yes ☐ No	Relationship:
14. Have you received the BCG vaccination?	☐Yes ☐ No	
15. Have you ever had a positive TB skin or blood test?	☐Yes ☐ No	Date:
16. Have you had a chest x-ray related to TB?	☐Yes ☐ No	Date:
17. Have you ever been treated with TB medications?	☐Yes ☐ No	

Please note: HIV infection and other medical conditions may cause a TB test to be negative even when TB infection is present. Persons with HIV infection and certain other medical conditions that may suppress the immune system are at significant risk of progressing to TB disease if they have TB infection. If you have HIV infection or other medical conditions that may suppress the immune system, discuss your risk of TB with your primary care provider.

To my knowledge, the above information is correct. I consent for an IGRA (TB) blood test, and/or chest x-ray, if applicable.

Applicant/Caregiver Signature: _____ **Date:** _____

For Clinic Use Only

(*) Risks: if any one question is marked yes, refer back to TB algorithm.

***(!)* Any questions 1-8 marked positive refer to TBQ Scoring Grid Standard Work.**

Caregiver Health Nurse Review: Based on current TB algorithm, I have reviewed the above and recommend:

☐IGRA ☐TST ☐Symptom review only

Caregiver Health Nurse Name (print): _____ Signature: _____ Date: _____

IGRA: Draw Date: _____Review Date: _____ IGRA Results: ☐Negative ☐ Positive

IGRA: Draw Date: _____ Review Date: _____ IGRA Results: ☐Negative ☐ Positive

Follow-up Action: ☐ No further follow up needed CHN Name: _____

CXR ordered; Date: _____ Results: ☐Negative ☐ Positive CHN Name: _____

For known history of positive TB test: TST on file? ☐Yes ☐No Date: _____ If yes, IGRA drawn? ☐Yes ☐ No

IGRA on file? ☐Yes ☐ No Date: _____ CXR on file? ☐Yes ☐ No Date: _____ Results: ☐ Neg ☐ Pos