



College of Nursing Immunization Requirements:

The required vaccinations for all College of Nursing programs are listed below. Please submit this form directly to Student Health Services once the entire form is completed by your primary care provider. Once Student Health Services processes your records, you can monitor your compliance status through the College of Nursing [Student Portal](#).

Submission Instructions:

- Once this form is completely filled out by your health care provider, this form and **all required supporting documentation** must be uploaded through [My BuckMD](#). Vaccination records should not be submitted to the Office of Student Affairs, Equity and Inclusion through CONcompliance@osu.edu.
- All medical documentation for compliance should be submitted at once utilizing this form, with the exception of those students who are being revaccinated for Hepatitis B.
- This form will be kept in your medical record at Student Health Services. Student Health Services will exchange health information with your academic program only for the purposes of determining compliance with program requirements under the Family Educational Rights and Privacy Act (FERPA).
- If you have any questions regarding specific immunization requirements, please contact the Preventive Medicine Coordinator at 614-247-2387 or preventivemedicine@osu.edu.
- Please allow Student Health Services 1-2 weeks for the processing of records. During times of high submission volume, this processing time may be even longer. Be sure to submit your documentation early enough ahead of any deadlines to remain compliant. You will receive a confirmation message from SHS once the document is processed.
- Non-health related compliance requirements submitted to Student Health Services will not be processed and will be deleted/shredded for security.

Please see the following pages for additional information regarding the various immunization and testing requirement for the College of Nursing.

Immunization and Testing Requirements

1. **Hepatitis B:** a complete vaccination series (either 2-dose or 3-dose) **AND** a positive surface antibody titer required.
 - If you have documented proof of a complete hepatitis B vaccination series, a titer must be collected to determine your antibody levels and immunity.
 - Positive results mean you are immune, and no additional vaccines or testing are required.
 - Negative results will require re-vaccination to raise your antibody levels, with a repeated titer required afterwards to check your immunity from the new vaccine(s).
 - Re-vaccination option 1: receive a booster dose of the Hepatitis B vaccine, then re-titer one month after vaccine administration.
 - Re-vaccination option 2: repeat entire 2-dose (HEPLISAV-B) or 3-dose vaccine series, then re-titer one month after the last dose.
 - If there is no documented proof of a complete hepatitis B vaccination series, a new series must be completed before a titer is collected. Positive hepatitis B surface antibody titers without proof of a complete vaccination series will not be accepted.
2. **Influenza:** a current and updated influenza vaccine required annually.
 - The new flu vaccines are usually available starting in late August/early September each year.
3. **MMR:** a complete 2-dose vaccine series required.
 - 2 doses of the MMR vaccine given after 1 year of age is acceptable for the requirement.
 - Measles, mumps, and rubella titers are only recommended if there is no proof of the vaccination history, but the student is certain they received the vaccines in the past.
 - Positive results mean you are immune, and no additional vaccines or testing are required.
 - Negative titer results will require re-vaccination, with no repeated titers required.
4. **Tdap:** one Tdap vaccine within the last 10 years required.
 - If Tdap vaccine is over 10 years old and expired, a TD or Tdap booster dose is required.
5. **Toxicology (drug) screen:** a negative 10-panel urine drug screen required upon entry to the program.
 - Results must show number of total drugs tested and overall/individual results with the date included.
6. **Tuberculosis:** initial negative 2-step PPD or QFT-G blood test; annual BuckeyeLearn training module required.
 - For the first year of the program, students are required to have an initial negative 2-step Tuberculosis skin test (PPD), which is two separate PPDs completed within 1-3 weeks of each other.
 - One negative TB blood test (QFT-G, T-Spot, or IGRA) will satisfy the 2-step PPD requirement.
 - In following years, the *Infection Prevention Starts With You* eLearning module on BuckeyeLearn must be completed to remain compliant – annual testing is only required for clinicals with a high risk of TB exposure.
7. **Varicella:** a complete 2-dose vaccine series required
 - 2 doses of the Varicella vaccine given after 1 year of age is acceptable for the requirement.
 - If a student never received the vaccines because of having Chickenpox in the past, a Varicella antibody titer is required to prove immunity from having the disease.
8. **COVID-19:** approved vaccination or approved medical/religious exemption required.
 - Acceptable vaccines: either the primary vaccine or series (original Pfizer 2-dose, Moderna 2-dose, or Janssen 1-dose) OR 1 dose of the most current COVID-19 monovalent vaccine (Pfizer, Moderna, Novavax).
 - For exemptions requests, please visit the CON immunization website for a copy of the required form.

Full Name: _____ Date of Birth: _____ Academic Program: _____

| Requirement | Required Documentation | | |
|--|--|---|---------------------------------|
| <p>Hepatitis B</p> <p>A full vaccine series AND a positive surface antibody titer required</p> <p>Note: a positive titer without proof of a full vaccine series will not be accepted</p> | <p>3 dose series (Engerix-B, Recombivax HB, Twinrix)</p> <p>Dose #1 date: _____</p> <p>Dose #2 date: _____</p> <p>Dose #3 date: _____</p> | <p>OR</p> <p>2-dose series (HEPLISAV-B)</p> <p>Dose #1 date: _____</p> <p>Dose #2 date: _____</p> | <p>Provider initials: _____</p> |
| | <p>Hepatitis B surface antibody titer (HBsAb)</p> | <p>Date Completed: _____ Result: _____</p> <p>Lab report attached <input type="checkbox"/></p> | |
| | <p>If the titer is negative, either a booster dose or a full series (either 2-dose or 3-dose) must be completed, with a repeated titer completed 4 weeks afterwards.</p> | | |
| <p>MMR (Measles, Mumps, Rubella)</p> <p>2 doses of the MMR vaccine required</p> | <p>MMR #1 date: _____</p> <p>MMR #2 date: _____</p> <p>Provider initials: _____</p> | | |
| | <p>**MMR titers only required if proof of vaccination is unable to be located**</p> | | |
| | <p>Positive Measles, Mumps, and Rubella antibody titers: Lab report attached <input type="checkbox"/></p> | | |
| <p>Tdap (Tetanus, Diphtheria, Pertussis)</p> | <p>Date: _____</p> | <p>**SELECT ONE**</p> <p>Adacel or Boostrix</p> | <p>Provider initials: _____</p> |
| | <p>Tdap must be re-administered every 10 years (TD booster acceptable after initial Tdap vaccine)</p> | | |
| <p>Varicella (Chickenpox)</p> <p>2 doses of the Varicella vaccine required</p> | <p>Varicella #1 date: _____</p> <p>Varicella #2 date: _____</p> <p>Provider initials: _____</p> | | |
| | <p>**Varicella titer only required if previously infected with the disease (Chickenpox) or if proof of vaccination is unable to be located**</p> | | |
| | <p>Positive Varicella antibody titer: Lab report attached <input type="checkbox"/></p> | | |

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All dates of service for vaccines and testing must be **before the date of the provider signature**

Full Name: _____ Date of Birth: _____ Academic Program: _____

| Requirement | Required Documentation | | |
|---|--|---|---|
| <p>Tuberculosis Screening</p> <p><u>First year ONLY:</u> Either a 2-step PPD OR TB blood test required</p> <p><u>Returning Students:</u> Completion of the Infection Prevention Starts With You eLearning module on BuckeyeLearn required (submit certificate to My BuckMD separately)</p> | <p>2-step tuberculin skin test</p> <p>PPD testing must meet the following criteria:</p> <ul style="list-style-type: none"> • Must be read in 48-72 hours by a certified health care provider with results documented in mm. • 2nd PPD must be placed 1-3 weeks after the placement date of the first. <p style="text-align: center;">OR</p> | <p>PPD #1 given: _____</p> <p>PPD #1 read: _____</p> <p>Result: _____ mm.</p> <p>Read by: _____</p> <p>Title: _____</p> | <p>PPD #2 given: _____</p> <p>PPD #2 read: _____</p> <p>Result: _____ mm.</p> <p>Read by: _____</p> <p>Title: _____</p> |
| <p>TB blood test (IGRA)</p> <p><i>Recommended for those that have received the BCG vaccine</i></p> | <p>Date Completed: _____ Result: _____</p> <p>Type of Test: _____ Lab report attached <input type="checkbox"/></p> | | |
| <p>Positive TB tests (either past or current) will require the completion of a one-time chest x-ray and annual Tuberculosis questionnaire. Please consult the Preventive Medicine department at Student Health Services to discuss appropriate next steps for the compliance requirement</p> | | | |
| <p>Drug Screen</p> <p>10-panel urine test</p> | <p>Completion Date: _____ Results: _____ Lab report attached <input type="checkbox"/></p> | | |
| <p>Influenza</p> <p>2025-2026 vaccine</p> | <p>Dose date: _____ Provider initials: _____</p> <p>NOTE: Vaccine does NOT automatically transfer from OSUWMC or Employee Health flu blitzes</p> | | |
| <p>UPLOAD YOUR COVID-19 VACCINE CARD SEPARATELY FROM THIS FORM</p> | | | |
| <p>Provider Information</p> <p>MD, DO, CNP, PA, RN signature required for this document to be valid</p> | <p>Name/Credentials: _____</p> <p>Address: _____</p> <p>Phone: _____</p> <p>Signature: _____ Date Completed: _____</p> | | |

All dates of service for vaccines and testing must be **before the date of the provider signature**

Full Name: _____ Date of Birth: _____ Academic Program: _____

Hepatitis B Revaccination

Only complete this page if your initial Hepatitis B surface antibody titer was negative

Please submit this document *as each dose is received* so you can remain temporarily compliant throughout the entire revaccination process. Revaccination should begin as soon as possible after the initial negative titer is returned.

| | | |
|--|---|---|
| OR | | |
| <p>3-dose series (Engerix-B, Recombivax HB, Twinrix)</p> <p>Single booster dose or full series accepted</p> <p>Repeat titer required 4 weeks after last dose received</p> | Booster / Dose #1: _____ | Signature/credentials: _____ Location: _____ |
| | Dose #2: _____ | Signature/credentials: _____ Location: _____ |
| | Dose #3: _____ | Signature/credentials: _____ Location: _____ |
| OR | | |
| <p>2-dose series (HEPLISAV-B)</p> <p>Single booster dose or full series accepted</p> <p>Repeat titer required 4 weeks after last dose received</p> | Booster / Dose #1: _____ | Signature/credentials: _____ Location: _____ |
| | Dose #2: _____ | Signature/credentials: _____ Location: _____ |
| AND | | |
| <p>Repeated Hep B Surface Antibody Titer</p> <p>Complete 4-6 weeks after last dose of the vaccine</p> | Date Completed: _____ | Result: _____ |
| | Supporting documentation for the surface antibody titer is required in order to be accepted | |
| | <p>If repeated titer is still negative, please contact the Preventive Medicine department at Student Health Services for advice on the next steps for compliance.</p> | |
| (END OF DOCUMENT) | | |