

**Montana State University, College of Nursing
Immunization, CPR, & Background Check Record**

Name: _____ DOB: ____/____/____ ID: _____
MM / DD / YYYY

Requirements	#1 Dose	#2 Dose	#3 Dose	Titer	CON faculty Initials
TDap Date					
Measles Date			OR	Immune; Not Immune Date:	
Mumps Date			OR	Immune; Not Immune Date:	
Rubella Date			OR	Immune; Not Immune Date:	
HBV (Hepatitis B)* Date				Immune; Not Immune Date:	
HBV (Repeat Series) Date				Immune; Not Immune Date:	
Varicella Date		1 month later	OR	Immune; Not Immune Date:	
TB Results (2-Step)**	Date applied	1-3 weeks after 1 st step Date applied	OR	Previous Date applied	#1
	Date read _____mm	Date read _____mm		Date read _____mm	#2

Requirements	Lower Division	Faculty Initials	Upper Division ~Junior~	Faculty Initials	Upper Division ~Senior~	Faculty Initials
CPR Date Completed	(AHA) (ARC)		(AHA) (ARC)		(AHA) (ARC)	
TB Results Date			_____mm		_____mm	

Background Check: Date Completed _____ (No copy required)

Notes:

CON Faculty Signature:

_____ Initials Signature Date	_____ Initials Signature Date
_____ Initials Signature Date	_____ Initials Signature Date

Requirements (see Policy A-32 for full details):

TDap – 1 dose (do not confuse with DTaP)

MMR – 2 doses OR positive rubella titer

*Hepatitis B – 3 doses followed by positive titer; if negative titer, see policy

Varicella – 2 doses OR positive titer; if negative titer, must have 2 doses (no follow-up titer required)

**TB – Initial 2-step required unless has had a test within the last 5 years

CPR – Annual “health care provider” update required