Certified Nurse Aide Program

*Nurse Aide students are required to authorize a criminal background check and provide proof of all required immunizations **PRIOR** to the registration deadline. The cost of the background check is included in your tuition and fees.*

Background & Immunization DEADLINE
1 Week Before Class Starts

(Please be mindful that it may take 3 days to receive your TB results.)
This date is set for RESULTS needed to finalize the registration process.
All forms must be completed no later than the first day of class.

RETURN FORMS TO TJC WEST
1530 SSW Loop 323, Tyler, TX 75701

- Immunizations must be current.
- TB results are only valid for 1 year.
  - ***TB results will take up to three (3) consecutive days to be read.***
- Optional locations for immunizations (At your own cost)
  - Your Personal Physician
  - Walgreens
  - CVS
  - Northeast Texas Public Health Clinic
- ***Immunizations may be faxed to (903) 510-2931 or hand delivered***
- TJC only accepts the following for proof of immunizations:
  - The form attached with the clinical site and physician's signature
  - Copies of the original
  - NETPHD cards

We will not accept photocopies

The background check fee is non-refundable. Cancellation refunds will not include the background check fee. Please fill out the background check authorization forms attached or by scanning this QR Code below.

Background Check Authorization Form

IMMUNIZATION RECORD
ALLIED HEALTH AND NURSING STUDENT

Last Name	First Name	Middle	Maiden
Address-Number & Street	**City**	**State**	**Zip**
Phone Number	**Date of Birth**	**Sex**	**Social Security Number/ (A#)**

Copies of documentation of immunizations may be stapled to this form. Primary care provider may initial by date given and sign at the bottom of the form. All initials must correspond with signatures.

REQUIRED

Tuberculosis (TB Test) * -Date Skin Test Read _____/_____/_____ Positive / Negative
Within the year Month Day Yea Results (circle one)

Tetanus/Diphtheria -Date of Last Dose _____/_____/_____
Must have had one dose within past ten years Month Day Year

MMR** -Dates of Doses **1st** _____/_____/_____
(Measles, Mumps, Rubella) Month Day Year
2nd _____/_____/_____
Month Day Year

Varicella (Chicken Pox) *** -Dates of Doses **1st** _____/_____/_____
Month Day Year
2nd _____/_____/_____
Month Day Year

Hepatitis B**** -Dates of Doses **1st** _____/_____/_____
One dose required before starting Month Day Year
Health Care program clinical unless pregnant. **2nd** _____/_____/_____
Month Day Year
3rd _____/_____/_____
Month Day Year

Influenza (Flu) **** Date of Last Dose _____/_____/_____
Must have during the active Flu Seasons – **October - May** Month Day Year

* Students who have a positive skin test must submit a chest X-Ray report which verifies that they are negative for TB.

***Measles component:* Adults born before 1957 can be considered immune to measles. Adults born during or after 1957 are required to have 1 dose of MMR unless they have a medical contraindication, documentation of more than 1 dose, history of measles based on health-care provider diagnosis or laboratory evidence of immunity.
Mumps component: Adults born before 1957 can be considered immune to mumps. Adults born during or after 1957 are required to have one dose of MMR unless they have a medical contraindication, history of Mumps based on health-care provider diagnosis, or laboratory evidence of immunity. Unvaccinated health care workers born before 1957 who do not have other evidence of immunity should have one dose of MMR and consider a second dose during an outbreak.
Rubella component: One dose of MMR is required except for women who are pregnant or those who supply lab evidence of immunity. For pregnant women who have not previously received MMR, documentation of immunization is required on completion or termination of pregnancy. 2nd dose required for adults who are students in post-secondary educational institute or working in a health- care facility.

***Varicella: One dose required before starting course. Health care workers should receive 2 doses of single-antigen Varicella Vaccine unless they have a medical contraindication. Pregnant women who do not have evidence of immunity should receive the first dose of Varicella vaccine upon completion or termination of pregnancy and before discharge from the health-care facility. The second dose should be administered 4 -8 weeks after the first dose.
Evidence of immunity to Varicella in adults includes any of the following: 1) documentation of 2 doses of Varicella vaccine at least 4 weeks apart; 2) History of Varicella based on health – care provider diagnosis 3) laboratory evidence of immunity or lab confirmation of disease.

********Texas Department of Health Rule 97.61-97.72 states that students who elect to not acquire the Hepatitis B series must sign a waiver. For more information please contact West Campus Administration Office (903) 510-2900.

PROOF OF IMMUNITY
TEXAS Administrative Health Code Chapter Section 97, Subchapter B
Verification of measles illness, rubella illness, or mumps illness. Section 97.63 of this title, "Required Immunizations," states that physician-validated histories of measles or mumps illnesses are acceptable in lieu of vaccine. All histories of measles or mumps illnesses must be supported by a written statement from a physician licensed to practice medicine in the United States. The physician's statement should contain wording such as: "This is to verify that (name of child or student) had measles or mumps illnesses on or about (dates) and does not need measles or mumps vaccine". **A copy of the statement must be attached to the child's or student's immunization record and the original should be returned to the student or the student's parent or guardian. If a child or student is unable to submit a physician's statement, then measles or mumps vaccine is required. A PHYSICIAN'S STATEMENT OF RUBELLA ILLNESS WITHOUT SEROLOGIC DOCUMENTATION WILL NOT SUBSTITUTE FOR RUBELLA VACCINE.** All serologic evidence of measles, rubella or mumps illnesses must consist of a written statement from a physician licensed to practice medicine in the United States or a laboratory report indicating confirmation of the disease (a confirmatory blood titer). See attached forms to provide verification.

Signature-Licensed Primary Care Provider Date Address City/State