FORM 3

THE UNIVERSITY OF ALABAMA
CAPSTONE COLLEGE OF NURSING

SENIOR (Semester IV) NURSING STUDENT IMMUNIZATION FORM

To be completed by physician or certified registered nurse practitioner and submitted annually while enrolled in the nursing program. Back of form may be used for additional comments when necessary.

NAME_____CWID #: _____

Tuberculin Skin Test:* Place skin test and read 48 hours later.

Date Tested _____ Date Read _____ Results _____

OR

IGRA Blood Test Date:* _____ (attach lab report).

If positive, annual chest X-ray and report are required.

Name of Physician, PA or Nurse (Please Print) and official stamp	Signature **(REQUIRED)**	Date

***Negative TB skin test (or CXR) must be in effect for entire academic semester (preferably for the year).**

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