POLICY

Immunization against communicable diseases is necessary for the prevention of illness.

1. All faculty will show proof of current:
   a. MMR immunization or serologic confirmation of immunity; if serologic confirmation of immunity is negative, then proof of one booster is required.
   b. TdaP (tetanus-diphtheria and pertussis) immunization every 10 years;
   c. Hepatitis B series or serologic confirmation of immunity; if serologic confirmation of immunity is negative, then proof of one booster is required.
   d. Two (2) doses of varicella vaccine or serologic confirmation of immunity; if serologic confirmation of immunity is negative, then proof of one booster is required.
   e. Flu vaccine – annually by November 1\textsuperscript{st} of the current academic year
   f. Meningococcal vaccine after the age of 16

2. All faculty will show annual proof of a negative TB skin test or a negative TB blood test (IGRA).
   o Faculty with positive results on TB skin test or TB blood test (IGRA) will be required to submit a current (within last 6 months) clear chest x-ray.
   o If treatment for TB is in progress or has been completed, faculty must provide documentation from healthcare provider.
   o Upon annual renewal, if faculty does not show annual proof of a negative TB skin test or a negative TB blood test (IGRA), then the faculty must provide documentation of annual TB symptom screen signed by healthcare provider. Please see attached form.
PROCEDURE

1. Each faculty member is responsible for submitting records to the School of Nursing showing proof of current immunizations as listed above.

2. All faculty will have all immunizations current and documented in the School of Nursing.

3. All faculty members must comply with any additional immunization requirements of the clinical agencies in which they practice.

Waiver:

Waivers must be in compliance with the rules and regulations of the Texas Department of Health, and accepted by the clinical agencies.
DeWitt School of Nursing
TB Exam Clearance Form

Student/Faculty Name: ____________________________________________
Student/Faculty ID #: ____________________________________________
Birth Date: ____________
Address: _______________________________________________________
City: __________________ Zip: ______
Telephone Number ________________________________
Date of last PPD ____________________________ PPD Results ________ MM
Date of IGRA (e.g., Quantiferon/T-Spot) test: __________________________ Results: ____________
Date of Last Chest X-Ray: __________________________ Results: ________ Positive for TB ________ Negative for TB

1. Have you ever been told you have active TB? ___ Yes ___ No
2. Have you ever taken INH or any other anti-TB drug? ___ Yes ___ No
If yes, list names of medications: ______________________________________

3. Date and duration of medication regime (months)
4. Have you ever had BCG Vaccination? ___ Yes ___ No If yes, when? _________________
5. During the past year have you noticed:
   □ Unexplained weight loss? ___ Yes ___ No
   □ Decrease in your appetite? ___ Yes ___ No
   □ Cough not associated with cold or flu? ___ Yes ___ No
   □ Increase in AMOUNT of Sputum? ___ Yes ___ No
   □ Change in COLOR of Sputum? ___ Yes ___ No
   □ Change in CONSISTENCY of Sputum? ___ Yes ___ No
   □ Blood Streaked Sputum? ___ Yes ___ No
   □ Night sweats? ___ Yes ___ No
   □ Unexplained low grade fever? ___ Yes ___ No
   □ Unusual tiredness or fatigue? ___ Yes ___ No
   □ Swelling of lymph nodes? ___ Yes ___ No
   □ Have you had contact with a family member or partner who has been diagnosed with TB?
     ___ Yes ___ No
   □ Have you or a member of your family been exposed to someone who is immune compromised?
     ___ Yes ___ No

Explain any “Yes” answers above:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Evaluation:
_____ I have examined above patient and found them to be free of TB disease. No further action is required

_____ Chest X-ray or TB blood test requested

_____ Further evaluation required

Signature of Health Provider: ___________________________ Date ____________
Provider Printed Name: ____________________________________________