STANDARD POLICY

POLICY

Immunization against communicable diseases is necessary for the health of students, clients, and the public. Immunization is mandated by the Texas Department of Health, the University, and our clinical agencies.

1. All students will show proof of current:
   a. MMR immunization or serologic confirmation of immunity;
   b. TdaP (tetanus-diphtheria and pertussis) immunization;
   c. Hepatitis B series or serologic confirmation of immunity;
   d. Two (2) doses of varicella vaccine or serologic confirmation of immunity;
   e. Polio vaccine
   f. Meningococcal vaccine (a booster may be required)
   g. Flu vaccine – annually by November 1st of the current academic year.

2. All students will show annual proof of a negative TB skin test or negative TB blood test (IGRA).
   o Students 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, student must provide documentation from healthcare provider.
   o Upon annual renewal, if student does not show annual proof of a negative TB skin test or negative TB blood test (IGRA), then the student must provide documentation of annual TB symptom screen signed by healthcare provider. Please see attached form.
PROCEDURE

1. Each student shall submit records to Student Health Services showing proof of current immunizations as listed above.

2. Each student shall also submit records to the School of Nursing showing proof of current immunizations as listed above.

3. If a student has a significant reaction to the TB skin test (10 mm or more), that student will be referred to the Texas Department of Health (TDH) for follow-up. Students will be placed on suspension from class and clinical until proof of clearance from the TDH has been presented by the student to the School of Nursing.

4. All students SHALL have all immunizations current and documented in the School of Nursing.

5. If a student fails to meet the above requirements and fails to have all immunizations current and documented in the School of Nursing prior to the first class day of each semester, the student will not be allowed to attend clinical. Failure to attend clinical results in an F-day(s).

6. It is the student’s responsibility to maintain currency of vaccinations.

Waiver:

Waivers must be in compliance with the rules and regulations of the Texas Department of Health as set forth below:

Exclusions from compliance are allowable on an individual basis for medical contraindications, reasons of conscience, including a religious belief, and active duty with the armed forces of the United States. Students in these categories must submit evidence for exclusion from compliance as specified by law.

(1) To claim exclusion for medical reasons, the student must present a statement signed by a physician who has examined the student, in which it is stated that, in the physician’s opinion, the vaccine required is medically contraindicated or poses a significant risk of the health and well-being of the student or any member of the student’s household. Unless it is written in the statement that a lifelong condition exists, the exemption statement is valid for only one (1) year from the date signed by the physician.

(2) To claim exclusion for reasons of conscience, including a religious belief, a signed affidavit must be presented by the student or the student’s parent or guardian, stating that the vaccinations are declined for reasons of conscience, including religious beliefs. The affidavit will be valid for a two-year period. The student, who has not received the required immunizations for reasons of conscience, including religious beliefs, may be excluded from classes, including clinicals, in times of emergency or epidemic declared by the commissioner of public health.

Policy No. 7
Page 2
(A) A person claiming exclusion for reasons of conscience, including a religious belief, from a required immunization may only obtain the affidavit form by submitting a written request to the department. The request must include:

(i) full name of student;

(ii) student’s date of birth (month/day/year)

(B) Written requests must be submitted through the United States Postal Service (or other commercial carrier), by facsimile, or by hand delivery to the department’s Bureau of Immunization and Pharmacy Support, 1100 West 49th Street, Austin, Texas 78756.

(C) Upon request, one affidavit form for each student will be mailed unless otherwise specified (shall not exceed a maximum of five forms per student).

(D) The department shall not maintain a record of the names of individuals who request an affidavit and shall return the original request with the forms requested.

(3) To claim exclusion for armed forces, persons who can prove that they are serving on active duty with the armed forces of the United States are exempted from the requirements.
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: ____________________________________________