

SAN JOSÉ STATE UNIVERSITY  
 School of Nursing  
**Health and Immunization Information - Master's Students**

Name: \_\_\_\_\_  
 (print clearly—last, first, middle)

First Semester in SJSU Nursing Courses: \_\_\_\_\_

Student ID #: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Soc. Sec. #: \_\_\_\_\_

**\*\*Attach copies of documents validating information entered.\*\***

Circle either below:	Date	Results	Date	Results	Date	Results
Measles/ MMR-titer or vaccine						
Varicella active disease or titer (chicken pox)						
Diphtheria & Tetanus within the last 10 years						
Polio: 1, 2, 3, 4						
Rubella Titer/Vaccine						
Hepatitis B Vaccine						

	Malpractice Provider	Expiration Date	CPR	Expiration Date	Health Insurance Policy No.	Expiration Date	PPD Date (date received) OR Chest x-ray Results date
Entry							
First Practicum							
Second Practicum							
Third Practicum (When Applicable)							

I agree to notify the Director of the School of Nursing at SJSU in writing of any changes in my physical or mental condition that may have an effect on my performance or continuation in the Nursing program. If I leave the program for a physical or mental problem, I am required to get a licensed health professional's evaluation of my fitness to return to Nursing School prior to starting nursing classes.

**Once you have read the above statement, please sign below.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_