The Western Massachusetts
Nursing Collaborative
Advancing Nursing ✓ Addressing Critical Needs

Documentations *(For students and faculty)*:

i. **Standardized Hepatitis B Vaccine Supplemental Form**
ii. **Standardized Influenza Exemption *AND* Declination Form**
iii. **Tuberculosis Symptom Screening**

Printed Name:_____Date of Birth:_____

School: _____ Matriculation Date: _____

Department: _____ Date: _____ Signature: _____

If you are not an employee, what is your role? Student ◯ Clinical Faculty ◯ Volunteer ◯ Other ◯

Standardized Hepatitis B Vaccine Supplemental Form - *For students and faculty who have previously received the Hepatitis B Vaccination series.*

I understand that due to my educational and or vocational exposure to blood or other potentially infectious bodily fluids I may be at risk of acquiring hepatitis B virus (HBV). I have been given the opportunity to be vaccinated with hepatitis B vaccine at my own expense.

Please indicate which of the following scenarios apply by your placing initials on the line provided:

a. _____ I decline hepatitis B vaccination at this time as I have proof of immunity by a positive anti-HBs blood titer, formerly known as the hepatitis B surface antibody (HBSAB). I have attempted to find documentation of my prior hepatitis B vaccinations, which I believe occurred in_____(date) at the office or workplace of _____. However, I am unable to find these records at this time.

b. _____ I am in the process of getting the hepatitis B series.

c. _____ It is documented that I do not respond to the vaccine

If I continue to have exposure to blood or other potentially infectious materials as part of my educational program or major and want to be vaccinated with the hepatitis B vaccine, I can receive the vaccination series at my own expense at any time in the future.

Western Massachusetts Standardized Influenza Exemption and Declination Form

By signing below, I acknowledge that I am aware of the following facts:

1. Influenza is a serious respiratory disease that kills an average of 36,000 persons and hospitalizes more than 200,000 persons in the United States each year.
2. Influenza vaccination is recommended for me and all other healthcare workers to protect our patients from influenza disease, its complications, and death.
3. If I contract influenza, I will shed the virus for 24–48 hours before influenza symptoms appear. My shedding the virus can spread influenza disease to patients in this facility.
4. If I become infected with influenza, even when my symptoms are mild or non-existent, I can spread severe illness to others.
5. I understand that the strains of virus that cause influenza infection change almost every year, which is why a different influenza vaccine is recommended each year.
6. I understand that I cannot get influenza from the influenza vaccine.
7. The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including my patients and other patients in this healthcare setting, my coworkers, my family, my community.
8. I have been given the opportunity to be vaccinated at no charge.
9. There are 3 formulations available:
    - The inactivated Intramuscular Influenza Vaccine
    - The inactive Intradermal for ages 18-64
    - The egg free Flublok influenza vaccine for ages 18-49

Despite these facts, I am requesting an exemption because of a medical contraindication to vaccination, an allergy to a vaccine component or because of a religious reason. I understand that any student/faculty who is exempted the flu vaccine must sign this form stating the specific reason for exemption because employers must report these to the CDC (in a non-identifiable way).

My reason for not receiving the vaccine is:

☐ I have a medical contraindication to vaccination or am allergic to a vaccine component.
☐ I object for religious reasons.
☐ I decline the 2025-2026 vaccine formulation.

☐ I understand that if I am exempted from receiving the flu vaccine and am working in an area where patients receive care, employers will require a mask.

Reference: CDC. Prevention and Control of Influenza with Vaccines—Recommendations of ACIP at www.cdc.gov/flu/professionals/acip/index.htm

Tuberculosis Symptom Screening

All students with a positive tuberculosis test result are asked to answer these questions about the signs and symptoms of active tuberculosis disease. Please answer every question to the best of your knowledge. Your results may be shared with the Public Health Department and/or with the representative of the clinical agency for any practicums associated with your program of study as applicable.

A. Have you had a positive tuberculin skin test in the past? ◯ Yes ◯ No

B. Have you been diagnosed with Tuberculosis in the past? ◯ Yes ◯ No

C. In the past year have you traveled outside the United States? ◯ Yes ◯ No

D. Have you ever had a BCG Vaccine (given outside the USA)? ◯ Yes ◯ No

E. Have you received preventative treatment for a Positive PPD? ◯ Yes ◯ No

F. Are you having any problems with persistent cough for more than 3 weeks? ◯ Yes ◯ No

G. Within the past year, have you had any known unprotected contact with someone with active tuberculosis? ◯ Yes ◯ No

H. Are you currently experiencing any of the following symptoms:

i. Unexplained weakness or fatigue ◯ Yes ◯ No

ii. Unexplained weight loss or poor appetite? ◯ Yes ◯ No

iii. Persistent cough ◯ Yes ◯ No

iv. Coughing up bloody mucus ◯ Yes ◯ No

v. Persistent low grade fever chills not related to a known infection? ◯ Yes ◯ No

vi. Night sweats not associated with any other condition? ◯ Yes ◯ No

Most recent Chest x-ray date: ___/___/_____ ☐ Never had a chest x-ray

If you had a chest x-ray within the past 5 years, please submit a copy of the report.

All persons with a positive interferon-gamma release assay (IGRA) or tuberculin skin test (TST) result for TB infection should be evaluated for active tuberculosis (TB) disease. This can be done in primary care or other clinical settings. The Massachusetts Department of Public Health supports a network of TB clinics in hospital facilities; referral to a TB clinic for this evaluation may be an option for primary care patients.

PPD Planted Date:_____Time _____ Provider_____

Lot Number: _____ Expiration Date: _____ Date Read: _____

Time: _____ Result: _____ Provider_____