

APPLICANT INFORMATION:

Name (PRINTED) \_\_\_\_\_ SCC ID# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_ Program \_\_\_\_\_

**NOTE: THIS FORM WILL NOT BE ACCEPTED IF ANY PORTION IS LEFT BLANK.**

If vaccination is not indicated for you, a physician must specify a reason or immunity must be proven by titer. If you choose to use Physicians Laboratory Services, Inc. for the titers, you cannot submit this form until results are received. Please see attached form for explanation.

■ **Tdap** (Tetanus, Diphtheria and Pertussis) Date: \_\_\_\_\_

■ **Chicken Pox** (Varicella-Zoster) 2 doses Date: \_\_\_\_\_ and \_\_\_\_\_

(First dose must be verified and student must submit written proof of second dose when received. CDC recommends a minimum of 28 days between doses).

OR **Varicella-Zoster Virus Titer** Date: \_\_\_\_\_ Findings: \_\_\_\_\_

■ **Mumps** (2 doses required or evidence of immunity) Date: \_\_\_\_\_ and \_\_\_\_\_

OR **Mumps Titer** Date: \_\_\_\_\_ Findings: \_\_\_\_\_

■ **Rubeola** (2 doses required or evidence of immunity) Date: \_\_\_\_\_ and \_\_\_\_\_

OR **Rubeola Titer** Date: \_\_\_\_\_ Findings: \_\_\_\_\_

■ **Rubella** (2 doses required or evidence of immunity) Date: \_\_\_\_\_ and \_\_\_\_\_

OR **Rubella Titer** Date: \_\_\_\_\_ Findings: \_\_\_\_\_

■ **Hepatitis B Antibody** Date: \_\_\_\_\_ Findings: \_\_\_\_\_

OR **Hepatitis B Vaccination** (Required for all health programs except Human Services) Three doses required: #1 to start, #2 one month later, and #3 five months after #2. If the series is in progress, first vaccination must be indicated and student must submit written proof of second and third doses as received.

Date: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

*If the series is interrupted, the CDC states you do NOT have to restart the series, just continue to complete the series.*

■ **Tuberculosis** skin test and/or chest x-ray (within last 12 months)

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

If the findings of the TB test are positive, student must have a chest x-ray and provide documentation. With documentation of a negative chest x-ray, no further testing is needed.

HEALTH CARE PROVIDER INFORMATION: \_\_\_\_\_

**Physician, Physician Asst. or RN information required. (If it is determined that provider information is falsified in any way, the student will be dismissed from the program and will not be eligible for admission to any health program at SCC.)**

Name (PRINTED): \_\_\_\_\_ Signature: \_\_\_\_\_

Clinic/Group Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_ Date form completed: \_\_\_\_\_

**Retain a copy and send original/copy to the Campus you will be attending:**

**Southeast Community College – Beatrice**  
Attn: Admissions Office  
4771 West Scott Road  
Beatrice, NE 68310-7042  
402-228-8214 or 1-800-233-5027

**Southeast Community College – Lincoln**  
Attn: Admissions Office  
8800 "O" Street  
Lincoln, NE 68520-1299  
402-437-2600 or 1-800-642-4075