SAMC AFFILIATED SCHOOL STUDENT ROSTER

SCHOOL: _____ ACADEMIC YEAR: _____

STUDENT TYPE: ☐ RN ☐ LVN ☐ Pharmacy ☐ PT ☐ RT ☐ Other: _____

STUDENT LEVEL: ☐ Beginning ☐ Intermediate ☐ Advanced

SCHOOL COURSE *(name & number)*: _____

CCPS REQUEST #: _____ Liability Insurance: (Provided by insurance company on file)

ROTATION AT SAMC

SEMESTER: ☐ Spring ☐ Summer ☐ Fall ☐ Winter

DAYS: ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri

START: _____ END: _____

HOURS:

Military Time (i.e., 0800 - 1400)

STUDENT INFORMATION					IMMUNIZATIONS									QUALIFICATIONS	
Last	First	Last 4 of SSN	Mobile #	Email	Rubeola	Mumps	Rubella	Varicella	Hep B	T-Dap	TB	Flu	Covid-19	CBC & Drug Screen	BLS (AHA)
Mobile #/Email are required for identity validation - please include area code with the mobile #.					2 Doses / Positive Titer: Please indicate "+" after date / Declination. For Hep B: 3 Dose Series / Positive Titer "+"/ Declination					Vaccine / Declination	Last Date Only	Seasonal (Oct - Mar)	Full Series (If applicable)	Dates Cleared (W/in 4 years)	Expiration Date
Doe	John	1234	5591234567	John.doe@samc.com	Date 1 Date 2	Date 1 Date 2	Date 1 Date 2	Date 1 Date 2	Date 1 Date 2 Date 3	Date 1	Date 1	Date 1	Date 1 Date 2 Date 3	Date 1	Date 1

INSTRUCTOR/SCHOOL DESIGNEE INFORMATION

Student information verified by Instructor / School Designee: _____

Instructor: _____ Phone (School): _____ Phone (Cell): _____

****PLEASE SUBMIT THIS ROSTER NO LATER THAN 2 WEEKS PRIOR TO EACH ROTATION TO:** Nursing.Education@samc.com

IMMUNIZATION AND CLEARANCE REQUIREMENTS

Must be completed 3 weeks prior to rotation start date

IMMUNIZATION DECLINATIONS:
It is the student's responsibility to seek declination approval through their school institution. If the student's request is approved, school faculty must list "Declination" in place of vaccination dates on the student roster. Once reviewed, SAMC will send the appropriate declination form to school faculty for student signature.

MMR	Rubeola	2 vaccines **OR** serological testing to demonstrate immunity.
	Mumps	2 vaccines **OR** serological testing to demonstrate immunity.
	Rubella	2 vaccines **OR** serological testing to demonstrate immunity.
Varicella	2 vaccines **OR** serological testing to demonstrate immunity.	
Hepatitis B	Series of 3 doses **OR** 2 dose HEPLISAV-B **OR** serological testing to demonstrate immunity.	
Pertussis (T-Dap)	Single vaccination	
TB Skin Test	Negative History	PPD every 12 months. Last date of TB required only. Cannot be older than one year unless chest x-ray within 5-year period.
	Positive History	Chest x-ray within 12 months/Documentation of positive skin test. If over 12 months, will accept surveillance form from MD.
Influenza	Vaccination for current season (October-March). Accepted immunization date cannot be earlier than August 1st of any given year.	
Covid-19	While the state of California has removed the COVID vaccination requirement, it is still highly recommended for healthcare providers.	
CBC & Drug Screen	Must be current (within the last 4 years) and reflect no break in course progression. Drug Screen must be 10-panel.	