

Incoming Student Immunization Requirements

Health Screening Requirements: Immunization/Infectious Disease Status:

NOTE: Comprehensive (childhood) immunization records must accompany titer results.

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

Birth date: \_\_\_\_\_ E-Mail: \_\_\_\_\_

MMR (Measles, Mumps, Rubella) – Two (2) doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and one (1) dose of Rubella; in addition, serologic proof of immunity for Measles, Mumps and Rubella, or proof of recent boosters.

Measles Serology: Specify the date and result of serologic blood test for Measles immunity. If the result is negative or equivocal, a booster vaccine after the date of the blood test is required.

Test Date: \_\_\_\_\_ Result: \_\_\_\_\_positive \_\_\_\_\_negative

Measles Immunization: (only required if Measles [Rubeola] titer is negative or equivocal) Specify the date of Measles immunization.

Date of Booster: \_\_\_\_\_

Rubella Serology: Specify the date and result of serologic blood test for Rubella immunity. If the result is negative or equivocal, a booster vaccine after the date of the blood test is required.

Test Date: \_\_\_\_\_ Result: \_\_\_\_\_positive \_\_\_\_\_negative

Rubella Immunization: (only required if Rubella titer is negative or equivocal) Specify the date of Rubella immunization.

Date of Booster: \_\_\_\_\_

Mumps Serology: Specify the date and result of serologic blood test for Mumps immunity. If the result is negative or equivocal, a booster vaccine after the date of the blood test is required.

Test Date: \_\_\_\_\_ Result: \_\_\_\_\_positive \_\_\_\_\_negative

Mumps Immunization: (only required if Mumps titer is negative or equivocal) Specify the date of Mumps immunization.

Date of Booster: \_\_\_\_\_

Measles, Mumps, and Rubella (MMR) Vaccination: (satisfies requirement for Measles, Mumps, and Rubella if any of the titers were negative or equivocal). Specify the date of MMR immunization.

Date of Booster: \_\_\_\_\_

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**Varicella** – Two (2) doses of Varicella vaccine, **plus** serologic proof of immunity, or proof of recent re-vaccination.

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**Varicella Serology:** Specify the date and result of serologic blood test for Varicella immunity. If the result is **negative or equivocal**, a booster vaccine after the date of the blood test is required.

Test Date: \_\_\_\_\_ Result: \_\_\_\_\_positive \_\_\_\_\_negative

**Varicella (Chicken Pox) Immunization:** (only required if Varicella titer is negative) Specify the date of Varicella immunizations.

Two additional doses required

Date for Dose 1: \_\_\_\_\_

Date for Dose 2: \_\_\_\_\_

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**Tetanus, Diphtheria and Pertussis** – One (1) dose of adult Tdap vaccine. If last Tdap is more than 10 years old, new Td vaccination is required.

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**Tetanus, Diphtheria and Pertussis (Tdap) Immunizations:** Specify the date on which the dose was given:

Date of Most Recent Immunization: \_\_\_\_\_

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**Hepatitis B** – Three (3) doses of Hepatitis B vaccine, **plus** a QUANTITATIVE Hepatitis B Surface Antibody (titer) preferably drawn 4 – 8 weeks after 3<sup>rd</sup> dose. If negative or equivocal, complete a second Hepatitis B series followed by a repeat titer. If Hepatitis B Surface Antibody is negative after secondary series, additional testing including Hepatitis B Surface Antigen should be performed.

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**Primary Hepatitis B Immunization Series:** Specify the date that each dose of Hepatitis B vaccine was given.

Three doses are required.

Date for Dose 1: \_\_\_\_\_

Date for Dose 2: \_\_\_\_\_

Date for Dose 3: \_\_\_\_\_

**Quantitative Hepatitis B Surface Antibody Serology:**

Specify the date and result of Hepatitis B surface antibody titer.

Test Date: \_\_\_\_\_ Result: \_\_\_\_\_positive \_\_\_\_\_negative

**Secondary Hepatitis B Immunization Series:** *(only required if titer shows no response to primary series)* Specify the date that each dose of Hepatitis B vaccine was given. Three doses are required.

Date for Dose 4: \_\_\_\_\_  
Date for Dose 5: \_\_\_\_\_  
Date for Dose 6: \_\_\_\_\_

**Quantitative Hepatitis B Surface Antibody Serology:** *(only required if secondary series was required)*  
Specify the date and result of Hepatitis B surface antibody titer.

Test Date: \_\_\_\_\_ Result: \_\_\_\_\_positive \_\_\_\_\_negative

**Hepatitis B Non-Responder:** *(If Hepatitis B Surface Antibody is negative after Primary and Secondary series)*  
Specify the date and result of Hepatitis B surface antigen AND core antibody titers.  
*Copies of results must be attached.*

**Chronic Active Hepatitis B:** *Documentation is required for rotations and counseling purposes.*

Hepatitis B Surface Antigen Date: \_\_\_\_\_

Hepatitis B Viral Load Date: \_\_\_\_\_

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***Infectious disease status reviewed and updated (by signing below, primary care clinician certifies this to be true).***

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Signature of Clinician: \_\_\_\_\_ Date: \_\_\_\_\_

Name and Title: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_