Immunization Requirements

A. All students must provide proof of completion of the Hepatitis B series of immunizations and serologic testing of immunity to Hepatitis B (titer). If Hepatitis B Titer is negative, repeat booster and re-do titer in 4 to 8 weeks.

B. Students born after 1956 must provide proof of immunization to Measles, Mumps, and Rubella (MMR) or are required to have serologic evidence of immunity to MMR (titer).

C. All students must provide proof of an annual PPD Tuberculin skin test. Students who test positive to PPD or have received the BCG vaccine, must provide results of a QFT blood test dated March 2018 or later.

D. All students must provide proof of Varicella (Chicken Pox) immunization or serologic evidence of immunity to Varicella (titer) or documented case of Chicken Pox.

E. All students must provide proof of a Tetanus (Td) booster within the past 10 years, and a one-time adult dose of Pertussis (Tdap).

F. All students are required to receive an Influenza vaccination each "flu season" in accordance with CDC Healthcare Personnel recommendations.

All visiting students must submit a University of Michigan Medical School 2018-19 VSAS Record of Required Immunizations form signed by a healthcare provider. The form must include a record of all completed vaccinations or vaccinations that are in progress at the time of submission. An annual PPD Tuberculin skin test is required and must be valid at the time of your scheduled clinical rotation at the University of Michigan Medical School. Those with a test date of March 2018 must provide an updated PPD Tuberculin test result if their clinical experience is scheduled after February 2019.
PART I - TO BE COMPLETED BY THE STUDENT (all fields are required)

Name: __________________________________________________________
Last: ____________________________________ First: _______ MI: ______
Street Address: __________________________________________________
City: __________________________ State: __________________ Zip Code: __________
Date of Birth: __________ Email: __________________ SSN: __________
Country of Citizenship: __________________________
Phone: (_____) __________________________

PART II - TO BE COMPLETED AND SIGNED BY A LICENSED HEALTH CARE PROVIDER

A. Hepatitis B Vaccination
1. Dose 1: __________________________ Month/Year __________
2. Dose 2: __________________________ Month/Year __________
3. Dose 3: __________________________ Month/Year __________
4. Antibody Titer (Required)
   Result: Positive/Immune _______ Negative/Non-Immune _______ Month/Year __________
   • If Negative: Booster ______________________________________________ Month/Year __________
   • New Titer Result: Positive/Immune _______ Negative/Non-Immune _______ Month/Year __________

B. Measles, Mumps, and Rubella
1. Dose 1: __________________________ Month/Year __________
2. Dose 2: __________________________ Month/Year __________
   Or . . .
3. Immune Titer (Positive/Immune), __________________________ Month/Year __________

C. Tuberculosis
1. PPD Negative dated March 2018 or later, __________________________ Month/Year __________
2. PPD Positive, then Quantiferon Gold Test (QFT) dated March 2018 or later
   QFT Result: Positive _______- Negative _______- __________________________ Month/Year __________
   • If QFT positive – referred for evaluation and treatment: Yes _______- No _______
3. EXCEPTION: Known exposure in past to BCG, then QFT dated
   March 2018 or later (Re-test Annually), __________________________ Month/Year __________

D. Chicken Pox (Varicella)
1. Documented case of Chicken Pox __________________________ Yes No (circle one)
   Or
2. Two doses of Varicella Vaccine
   • Dose 1: __________________________ Month/Year __________
   • Dose 2: __________________________ Month/Year __________
   If Neither 1 or 2 above . . .
3. Immune Titer (Positive/Immune), __________________________ Month/Year __________

E. Tetanus/Pertussis (Within past 10 years)
1. Most recent Tetanus booster __________________________ Month/Year __________
2. One-time adult dose of Tdap (Required) __________________________ Month/Year __________

F. Influenza Vaccine: (Proof of vaccine for 2018-19 must be subsequently be provided) __________ Month/Year __________

PART III - TO BE COMPLETED AND SIGNED BY A LICENSED HEALTH CARE PROVIDER

Name: __________________________________________________________
Address: ________________________________________________________
Signature: ______________________________________ Phone: (_____) ________

Revised: 01/2018