Immunization Requirements for Entering Medical Students

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 **MMR** (Measles, Mumps, and Rubella) or are required to have serologic evidence of immunity to MMR (titer).

C. All students must provide proof of a baseline **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 November 1 or later.

D. All students must provide proof of 2 Varicella vaccines or serologic evidence of immunity to Varicella (titer).

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 will be required to receive an Influenza vaccination each "flu season" in accordance with CDC Healthcare Personnel recommendations.

All entering students must submit a 'Record of Required Immunizations' form signed by a healthcare provider. The documentation must include a record of all completed vaccinations or vaccinations that are in progress at the time of submission. Subsequent, documentation proof for missing immunizations should be provided as vaccination requirements are met.

Revised 4/2020
PART I - TO BE COMPLETED BY THE STUDENT

Name: ________________________________________________
Last                      First                      MI
Date of Birth: ____________________________________________
Street Address: _______________________________________________
City: __________________ State: __________ Zip: __________
Phone: (____)______________________  Today's Date: __________

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

A. Hepatitis B Vaccination
   1. ................................................................. Month/Year __________
   2. ................................................................. Month/Year __________
   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. 2 Doses of MMR Vaccine…………………………………… Month/Year __________ // __________
      Or . . .
   2. Immune Titer *(Required to be positive)* ………………… Month/Year __________

C. Tuberculosis
   1. If PPD Negative dated November 1, 2019 or later …………… Month/Year __________
   2. If PPD Positive, then QFT (Quantiferon Gold Test) dated November 1, 2019 or later
      QFT…… Positive ___ Negative __________ Month/Year __________
      • If QFT positive – refer for evaluation and treatment
      • If QFT negative – annual symptom review recommended
   3. EXCEPTION: Known exposure in past to BCG, then QFT dated November 1, 2019 or later.
      ……………………………………………………… Month/Year __________

D. Varicella
   1. Two doses of Varicella Vaccine ………………… Month/Year __________ // __________
      Or . . .
   2. Immune Titer: *(Required) Result…… Positive ___ Negative …… 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: *(Annual Requirement)* ………………… Month/Year __________

TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER

Name: __________________________________________
Address: __________________________________________
(Printed) Name: __________________________________
Signature: __________________________________________
Phone: __________________________________________