

The University of Michigan Medical School Immunization Requirements

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.

RECORD OF REQUIRED IMMUNIZATIONS

University of Michigan Medical School

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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)
Signature: Phone: