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 4/2021
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, 20________ …………………… Month/Year ____________
   2. If PPD Positive, then QFT (Quantiferon Gold Test) dated November 1, 20________ 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, 20________ 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: ____________________________

Submit Document to: UMMS.Health.Records@umich.edu