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

C. All students must provide annual proof of a 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 Varicella immunization or serologic evidence of immunity to Varicella (titer) or documented case of chickenpox.

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 by July 15, 2019. The form must include a record of all completed vaccinations or vaccinations that are in progress at the time of submission. Subsequent, documentation for missing immunizations should be provided as vaccination requirements are met.
2019 RECORD OF REQUIRED IMMUNIZATIONS  
University of Michigan Medical School  
1135 Catherine Street, Room 5100 SPC 5726 • Ann Arbor MI 48109-5726 • Phone (734) 764-0219 • Fax (734) 764-9473

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: *(U of M Medical School Requirement)*

   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, 2018 or later ………………… Month/Year

   (Re-test Annually)

2. If PPD Positive, then QFT (Quantiferon Gold Test) dated November 1, 2018 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, 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 …………………………………… Month/Year

   If Neither . . .

3. 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

TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER

Name: ____________________________ Address: ____________________________

(Printed) Signature: ____________________________ Phone: ____________________________

Revised: 1/2019