

# UNIVERSITY HEALTH SERVICES IMMUNIZATION HISTORY (To be completed by a physician)

|               |   |  |  |  |     |  |  |  |                     |
|---------------|---|--|--|--|-----|--|--|--|---------------------|
| Patient Name: |   |  |  |  | SS# |  |  |  |                     |
| Student ID    | M |  |  |  |     |  |  |  | College of Medicine |

## REQUIRED IMMUNIZATIONS

|                              |   |
|------------------------------|---|
| <b>DPT</b><br>Initial series | 5 childhood doses and booster every 10 years<br><b>Booster within 10 years required:</b><br><b>Dates of primary series</b><br>#1 _____ #2 _____ #3 _____ #4 _____ #5 _____ Did not receive <input type="checkbox"/> no record <input type="checkbox"/><br><b>Booster dates:</b> _____ (Td <input type="checkbox"/> or Tdap <input type="checkbox"/> Please check one) _____ (Td <input type="checkbox"/> or Tdap <input type="checkbox"/> Please check one) |
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**MINIMUM REQUIREMENT - Documentation of tetanus booster within the last 10 years. If you are due for a booster now, Tdap is recommended.**

|              |  |
|--------------|--|
| <b>Polio</b> | 3 childhood doses and booster: <b>*Booster date required:</b><br>Dates of primary series #1 _____ #2 _____ #3 _____ Booster _____<br>Did not receive <input type="checkbox"/> no record <input type="checkbox"/> |
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**MINIMUM REQUIREMENT - \*Booster date required, however booster not needed if 3<sup>rd</sup> dose given after age 4**

|                              |   |                             |   |
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| <b>MMR</b><br>Titer required | If titer is negative, booster is required:<br>Date of booster: _____<br>Re-titer: 4 weeks after booster | <b>If given separately:</b> | Mumps #1 _____ #2 _____<br>Measles (Rubeola) #1 _____ #2 _____<br>Rubella #1 _____ #2 _____ |
|------------------------------|---|-----------------------------|---|

**MINIMUM REQUIREMENT - MMR Titer – evidence of immunity to measles, mumps, rubella, by presenting lab report of positive titer . If titer result is negative, 1 dose of vaccine and repeat titer 4 – 6 weeks later.**

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| <b>Hepatitis B</b><br>Series | Dates of series #1 _____ #2 _____ #3 _____ Booster dates #4 _____ #5 _____ #6 _____ |
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**MINIMUM REQUIREMENT - Three dose series (second dose one month and third dose six months after first dose) and a lab report of HBSAB (positive hepatitis surface antibody) titer. If HBSAB result is negative, additional booster required and repeat titer. If negative give doses 5 and 6 then repeat titer 4 weeks later.**

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| <b>Varicella</b><br>*titer | If titer is negative - Dose #1 _____ #2 _____ |
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**MINIMUM REQUIREMENT - 2 doses of VZV vaccine. OR Varicella titer – (evidence of immunity to Varicella by presenting lab report of positive titer.)  
\* No titer is required if you present 2 VZV vaccine documents.**

| <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2" style="text-align: center;">SEROLOGIC PROOF IMMUNITY<br/>Must attach titer report</th> <th colspan="2" style="text-align: center;">Check one</th> </tr> <tr> <th style="width: 20%;">Test</th> <th style="width: 20%;">Date of Test</th> <th style="width: 10%;">Positive</th> <th style="width: 10%;">Negative</th> </tr> </thead> <tbody> <tr><td>Measles</td><td>/ /</td><td></td><td></td></tr> <tr><td>Mumps</td><td>/ /</td><td></td><td></td></tr> <tr><td>Rubella</td><td>/ /</td><td></td><td></td></tr> <tr><td>Varicella</td><td>/ /</td><td></td><td></td></tr> <tr><td>Hepatitis B</td><td>/ /</td><td></td><td></td></tr> </tbody> </table> | SEROLOGIC PROOF IMMUNITY<br>Must attach titer report |           | Check one |  | Test | Date of Test | Positive | Negative | Measles | / / |  |  | Mumps | / / |  |  | Rubella | / / |  |  | Varicella | / / |  |  | Hepatitis B | / / |  |  | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3" style="text-align: center;">2 STEP TB TEST</th> </tr> <tr> <th style="width: 30%;">Test</th> <th style="width: 30%;">Date</th> <th style="width: 40%;"></th> </tr> </thead> <tbody> <tr> <td>Step 1 Placement</td> <td>/ /</td> <td>Result</td> </tr> <tr> <td>Step 1 Reading</td> <td>/ /</td> <td></td> </tr> <tr> <td>Step 2 Placement</td> <td>/ /</td> <td>Result</td> </tr> <tr> <td>Step 2 Reading</td> <td>/ /</td> <td></td> </tr> </tbody> </table> <p style="font-size: small;">Placement date, reading date and results required. Proof of annual testing or 2 step, even for those who have received BCG vaccine as a child. If PPD skin test is positive: DOCUMENTATION IS REQUIRED. In addition, a chest x-ray documenting no active tuberculosis (within 1 year) must be submitted with +PPD documentation.</p> | 2 STEP TB TEST |  |  | Test | Date |  | Step 1 Placement | / / | Result | Step 1 Reading | / / |  | Step 2 Placement | / / | Result | Step 2 Reading | / / |  |
|---|--|-----------|-----------|--|------|--------------|----------|----------|---------|-----|--|--|-------|-----|--|--|---------|-----|--|--|-----------|-----|--|--|-------------|-----|--|--|---|----------------|--|--|------|------|--|------------------|-----|--------|----------------|-----|--|------------------|-----|--------|----------------|-----|--|
| SEROLOGIC PROOF IMMUNITY<br>Must attach titer report  |  | Check one |           |  |      |              |          |          |         |     |  |  |       |     |  |  |         |     |  |  |           |     |  |  |             |     |  |  |   |                |  |  |      |      |  |                  |     |        |                |     |  |                  |     |        |                |     |  |
| Test  | Date of Test   | Positive  | Negative  |  |      |              |          |          |         |     |  |  |       |     |  |  |         |     |  |  |           |     |  |  |             |     |  |  |   |                |  |  |      |      |  |                  |     |        |                |     |  |                  |     |        |                |     |  |
| Measles   | / /  |           |           |  |      |              |          |          |         |     |  |  |       |     |  |  |         |     |  |  |           |     |  |  |             |     |  |  |   |                |  |  |      |      |  |                  |     |        |                |     |  |                  |     |        |                |     |  |
| Mumps   | / /  |           |           |  |      |              |          |          |         |     |  |  |       |     |  |  |         |     |  |  |           |     |  |  |             |     |  |  |   |                |  |  |      |      |  |                  |     |        |                |     |  |                  |     |        |                |     |  |
| Rubella   | / /  |           |           |  |      |              |          |          |         |     |  |  |       |     |  |  |         |     |  |  |           |     |  |  |             |     |  |  |   |                |  |  |      |      |  |                  |     |        |                |     |  |                  |     |        |                |     |  |
| Varicella   | / /  |           |           |  |      |              |          |          |         |     |  |  |       |     |  |  |         |     |  |  |           |     |  |  |             |     |  |  |   |                |  |  |      |      |  |                  |     |        |                |     |  |                  |     |        |                |     |  |
| Hepatitis B   | / /  |           |           |  |      |              |          |          |         |     |  |  |       |     |  |  |         |     |  |  |           |     |  |  |             |     |  |  |   |                |  |  |      |      |  |                  |     |        |                |     |  |                  |     |        |                |     |  |
| 2 STEP TB TEST  |  |           |           |  |      |              |          |          |         |     |  |  |       |     |  |  |         |     |  |  |           |     |  |  |             |     |  |  |   |                |  |  |      |      |  |                  |     |        |                |     |  |                  |     |        |                |     |  |
| Test  | Date   |           |           |  |      |              |          |          |         |     |  |  |       |     |  |  |         |     |  |  |           |     |  |  |             |     |  |  |   |                |  |  |      |      |  |                  |     |        |                |     |  |                  |     |        |                |     |  |
| Step 1 Placement  | / /  | Result    |           |  |      |              |          |          |         |     |  |  |       |     |  |  |         |     |  |  |           |     |  |  |             |     |  |  |   |                |  |  |      |      |  |                  |     |        |                |     |  |                  |     |        |                |     |  |
| Step 1 Reading  | / /  |           |           |  |      |              |          |          |         |     |  |  |       |     |  |  |         |     |  |  |           |     |  |  |             |     |  |  |   |                |  |  |      |      |  |                  |     |        |                |     |  |                  |     |        |                |     |  |
| Step 2 Placement  | / /  | Result    |           |  |      |              |          |          |         |     |  |  |       |     |  |  |         |     |  |  |           |     |  |  |             |     |  |  |   |                |  |  |      |      |  |                  |     |        |                |     |  |                  |     |        |                |     |  |
| Step 2 Reading  | / /  |           |           |  |      |              |          |          |         |     |  |  |       |     |  |  |         |     |  |  |           |     |  |  |             |     |  |  |   |                |  |  |      |      |  |                  |     |        |                |     |  |                  |     |        |                |     |  |

## OTHER NOT REQUIRED

|                          |  |
|--------------------------|--|
| Hepatitis A Vaccine      | Date: _____  |
| Meningococcal Vaccine    | Date: _____  |
| BCG                      | Yes (Date: _____ ) No  |
| HPV Vaccine (Women only) | 1 <sup>st</sup> Dose _____ 2 <sup>nd</sup> Dose _____ 3 <sup>rd</sup> Dose _____ |
| Influenza Vaccine        | Date: _____  |
| Other                    |  |

## PRIMARY CARE PROVIDER SIGNATURE REQUIRED

Print Physician Name/Designee \_\_\_\_\_

Physician/Designee Signature \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_

Phone, with area code ( \_\_\_\_\_ ) \_\_\_\_\_