AAMC Standardized Immunization Form

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Last Name:		**First Name:**		**Middle Initial:**	
DOB:		**Street Address:**			
Medical School:		**City:**			
Cell Phone:		**State:**			
Primary Email:		**ZIP Code:**			
Student ID:		**Last 4 SS#:**			

MMR (Measles, Mumps, Rubella) *– 2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and (1) dose of Rubella; or serologic proof of immunity for Measles, Mumps and/or Rubella*

Option1	**Vaccine**	**Date**	
MMR *-2 doses of MMR vaccine*	MMR Dose #1	___/___/____	
	MMR Dose #2	___/___/____	
Option 2	**Vaccine or Test**	**Date**	
Measles *-2 doses of vaccine or positive serology*	Measles Vaccine Dose #1	___/___/_____	
	Measles Vaccine Dose #2	___/___/_____	
	Serologic Immunity (IgG, antibodies, titer)	___/___/_____	❑ Copy Attached
Mumps *-2 doses of vaccine or positive serology*	Mumps Vaccine Dose #1	___/___/_____	
	Mumps Vaccine Dose #2	___/___/_____	
	Serologic Immunity (IgG, antibodies, titer)	___/___/_____	❑ Copy Attached
Rubella *-1 dose of vaccine or positive serology*	Rubella Vaccine	___/___/_____	
	Serologic Immunity (IgG, antibodies, titer)	___/___/_____	❑ Copy Attached

Hepatitis B Vaccination *--3 doses of vaccine followed by a **QUANTITATIVE** Hepatitis B Surface Antibody (titer) preferably drawn 4-8 weeks after 3rd dose. If negative, complete a second Hepatitis B series followed by a repeat titer. If Hepatitis B Surface Antibody is negative after a secondary series, additional testing including Hepatitis B Surface Antigen should be performed. See: http://www.cdc.gov/mmwr/pdf/rr/rr6103.pdf for more information.*

Documentation of Chronic Active Hepatitis B is for rotation assignments and counseling purposes only.

	Date		
Primary Hepatitis B Series	Hepatitis B Vaccine Dose #1	___/___/_____	
	Hepatitis B Vaccine Dose #2	___/___/_____	
	Hepatitis B Vaccine Dose #3	___/___/_____	
	QUANTITATIVE Hep B Surface Antibody	___/___/_____	**Result** _____ mIU/ml ❑ Copy Attached
Secondary Hepatitis B Series (If no response to primary series)	Hepatitis B Vaccine Dose #4	___/___/_____	
	Hepatitis B Vaccine Dose #5	___/___/_____	
	Hepatitis B Vaccine Dose #6	___/___/_____	
	QUANTITATIVE Hep B Surface Antibody	___/___/_____	**Result** _____ mIU/ml ❑ Copy Attached
Hepatitis B Vaccine Non-responder (If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)	Hepatitis B Surface Antigen (if 2nd titer negative)	___/___/_____	❑ Copy Attached
	Hepatitis B Core Antibody (if 2nd titer negative)	___/___/_____	❑ Copy Attached
Chronic Active Hepatitis B	Hepatitis B Surface Antigen	___/___/_____	❑ Copy Attached
	Hepatitis B Viral Load	___/___/_____	❑ Copy Attached

Tetanus-diphtheria-pertussis – *One (1) dose of adult Tdap. If last Tdap is more than 10 years old, provide date of last Td and Tdap*

	Date	
Tdap Vaccine (Adacel, Boostrix, etc)	___/___/_____	
Td Vaccine *(if more than 10 years since last Tdap)*	___/___/_____	

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Name: _____ **Date of Birth:** _____
(Last, First, Middle Initial) (mm/dd/yyyy)

TUBERCULOSIS SCREENING – *Results of last (2) TSTs (PPDs) or (1) IGRA blood test are required **regardless** of prior BCG status. If you have a history of a positive TST (PPD)≥10mm or IGRA please supply information regarding any evaluation and/or treatment below. You only need to complete ONE section.*

Skin test or IGRA results should not expire during proposed elective rotation dates
or
must be updated with the receiving institution prior to rotation.

Tuberculin Screening History

Please complete one TB section only

Section A		Date Placed	Date Read	Reading	Interpretation
Negative Skin or Blood Test History	**TST #1**	___/___/____	___/___/____	____ mm	❑ Pos ❑ Neg ❑ Equiv
	TST #2	___/___/____	___/___/____	____mm	❑ Pos ❑ Neg ❑ Equiv
	TST #3	___/___/____	___/___/____	____ mm	❑ Pos ❑ Neg ❑ Equiv
			Date	**Result**	
Last two skin test or IGRAs required Use additional rows as needed	**IGRA Blood Test** (Interferon gamma releasing assay)		___/___/____	❑ Negative ❑ Indeterminate	❑ Copy Attached
	IGRA Blood Test (Interferon gamma releasing assay)		___/___/____	❑ Negative ❑ Indeterminate	❑ Copy Attached
	IGRA Blood Test (Interferon gamma releasing assay)		___/___/____	❑ Negative ❑ Indeterminate	❑ Copy Attached

Section B		Date Placed	Date Read	Reading	Interpretation
History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test	Positive TST	___/___/____	___/___/___	_____ mm	
			Date	**Result**	
	Positive IGRA Blood Test		___/___/____	_____ IU	❑ Copy Attached
	Chest X-ray		___/___/____		❑ Copy Attached
	Prophylactic Medications for latent TB taken?				❑ Yes ❑ No
	Total Duration of prophylaxis?				_____ Months
	Date of Last Annual TB Symptom Questionnaire (if applicable)			___/___/____	❑ Copy Attached

Section C		Date	
History of Active Tuberculosis	Date of Diagnosis	___/___/___	
	Date of Treatment Completed	___/___/____	❑ Copy Attached
	Date of Last Annual TB Symptom Questionnaire (if applicable)	___/___/____	❑ Copy Attached
	Date of Last Chest X-ray	___/___/____	❑ Copy Attached

Varicella (Chicken Pox) *-2 doses of vaccine or positive serology*

	Date	
Varicella Vaccine #1	___/___/_____	
Varicella Vaccine #2	___/___/_____	
Serologic Immunity (IgG, antibodies, titer)	___/___/_____	❑ Copy Attached

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Influenza Vaccine *--1 dose annually each fall*			
	Flu Vaccine	___/___/____	❑ Copy Attached
	Flu Vaccine	___/___/____	❑ Copy Attached

Additional Information:

Additional requirement:

Provide dates of childhood DPT/Tdap/Td vaccines: #1 _____ #2 _____ #3 _____

MUST BE COMPLETED BY YOUR HEALTH CARE PROVIDER OR INSTITUTIONAL REPRESENTATIVE:

Authorized Signature:		**Date:** ___/___/____
Printed Name:		Office Use Only
Title:		
Address Line 1:		
Address Line 2:		
City:		
State:		
Zip:		
Phone:	**(____)** _____-_____ **Ext:** _____	
Fax:	**(____)** _____-_____	
Email Contact:		

*Sources:

1. Hepatitis B In: Centers for Disease Control and Prevention. Epidemiology and Prevention of Vaccine-Preventable Diseases. Hamborsky J, Kroger A, Wolfe S, eds. 13th ed. Washington D.C. Public Health Foundation, 2015
2. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP), MMWR, Vol 60(7):1-45
3. Updated CDC Recommendations for the Management of Hepatitis B Virus–Infected Health-Care Providers and Students, MMWR Vol 61(RR03):1-12.

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