IMMUNIZATION HISTORY MUST BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER

*Copies of your original immunization records are acceptable in place of this form. Please submit completed form or immunization records directly to your UAB SH&W Patient Portal.

1. **MMR** - Measles, Mumps, and Rubella: All students must satisfy this requirement, either by two vaccine doses against each of the three diseases or laboratory evidence of immunity to all three diseases.

   **EITHER**

   Two doses of MMR vaccine:  
   Date: __/__/__  
   Date: __/__/__

   **OR**

   Two doses of each vaccine component:
   Measles  
   Date: __/__/__  
   Date: __/__/__

   Mumps  
   Date: __/__/__  
   Date: __/__/__

   Rubella  
   Date: __/__/__  
   Date: __/__/__

   **OR**

   Laboratory evidence of immunity to all three diseases:
   Measles  
   Date: __/__/__  Result: ________________

   Mumps  
   Date: __/__/__  Result: ________________

   Rubella  
   Date: __/__/__  Result: ________________

   *If any laboratory titers are non-immune, 2 repeat vaccines are required. Date: __/__/__  Date: __/__/__

2. **Tdap** - Tetanus, Diphtheria, Acellular Pertussis: All students must have had one dose of the adult Tdap given 2006 or later. If the last adult Tdap is greater than 10 years old, a Td booster is required.

   Tdap Date: __/__/__

   Td Date: __/__/__

3. **Hepatitis B Series**: All students must have a series of three Hepatitis B vaccinations (initial dose, dose two at 1 month, dose three at 6 months). A post-vaccine surface antibody titer (to demonstrate immunity) is required one month after 3rd vaccine dose.

   Dose 1 Date: __/__/__  
   Dose 2 Date: __/__/__  
   Dose 3 Date: __/__/__

   Hep B surface antibody titer:  
   Reactive: _____  Non-Reactive: _____  Date: __/__/__

   *If Hep B surface antibody is non-reactive, repeat series and post-vaccine surface antibody titer are required.

   Dose 1 Date: __/__/__  
   Dose 2 Date: __/__/__  
   Dose 3 Date: __/__/__

   Hep B surface antibody titer:  
   Reactive: _____  Non-Reactive: _____  Date: __/__/__

   *If repeat Hep B surface antibody is non-reactive, Hep B surface antigen is required to rule out acute or chronic Hep B infection.

   Hep B surface antigen titer:  
   Positive: _____  Negative: _____  Date: __/__/__

   **If Hep B surface antigen is positive, visit with SH&W provider is required for additional testing. If negative, student will be considered a non-responder.

4. **Varicella** (chickenpox or shingles): All students must have documented history of Varicella, a positive Varicella antibody titer, or two doses of Varicella vaccines given at least 28 days apart.

   **EITHER**

   History of Varicella (chickenpox or shingles):  
   Yes: _____  No: _____  Date: __/__/__

   **OR**
Varicella antibody titer

Positive: _____ Negative: _____  Date: _____/_____/_____

OR

Varicella vaccination Dose 1: _____/_____/_____  Dose 2: _____/_____/_____  
*If Varicella antibody titer is negative or equivocal, two repeat vaccinations are required.

Varicella vaccination Dose 1: _____/_____/_____  Dose 2: _____/_____/_____  

5. Meningococcal: All students 21 and younger are required to show documentation of a meningitis vaccine given on/after their 16th birthday. Students age 22 and older are exempt.  Date: _____/_____/_____ 

6. Tuberculosis: All clinical students must meet UAB’s Tuberculosis screening requirement. If no history of positive Tb skin test, two separate skin tests or one IGRA blood test are required upon matriculation. Skin tests must be placed at least one week apart.

   EITHER
   a. Tuberculin Skin Test (PPD) within 12 months prior to matriculation:
      Date Placed: _____/_____/_____  Date Read: _____/_____/_____  Result (mm): _________  Positive: _____  Negative: _____
   b. Tuberculin Skin Test (PPD) within 3 months prior to matriculation:
      Date Placed: _____/_____/_____  Date Read: _____/_____/_____  Result (mm): _________  Positive: _____  Negative: _____

   OR
   a. IGRA (Tspot or Quantiferon TB Gold) blood test and UAB TB Questionnaire within 3 months prior to matriculation:
      Date: _____/_____/_____  Positive: _____  Negative: _____
   b. UAB TB Questionnaire

*If positive skin test or IGRA result, Chest X-Ray within 3 months prior to matriculation and UAB TB Questionnaire required.
   a. Chest X-Ray Date: _____/_____/_____  Normal: _____  Abnormal: _____  (*Please attach results)
   b. UAB High Risk TB Questionnaire
   c. Have you been treated with anti-tubercular drugs? Yes: _____  No: _____

If yes, type of treatment: ___________________________  Length of Treatment: ___________________________  *Please attach supporting documentation.

 Verification of the above Student Immunization Record and Tuberculosis Screening by Health Care Provider:

Verified by: ___________________________________________  Title: ___________________________________________

Address: _______________________________________________________________________________________

Phone: __________________________________________________________

Signature: ___________________________________________________________  Date: _____/_____/_____  

Office Stamp (if Available):