UAB Student Health & Wellness Immunization Form

Clinical Domestic Students

NAME: _____ DATE OF BIRTH: (mm/dd/yyyy): _____

ADDRESS: _____ PHONE: _____

PROGRAM OF STUDY: _____ BLAZERID:_____@UAB.EDU

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: _____/_____/_____

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

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):