

UAB Student Health & Wellness Immunization Form

Clinical 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.**

FORMAT mm/dd/yyyy

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. First dose must have been received no sooner than one year after birth.

Two doses of MMR vaccine: **EITHER** 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: ____/____/____ Positive: ____ Negative: ____
Mumps Date: ____/____/____ Positive: ____ Negative: ____
Rubella Date: ____/____/____ Positive: ____ Negative: ____

*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.**

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

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. First dose must have been received no sooner than one year after birth.

EITHER

Yes: _____ No: _____

Date: ____/____/____

History of Varicella (chickenpox or shingles):

OR

Date: ____/____/____

Positive: _____ Negative: _____

Varicella antibody titer

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 ACWY**: All students 21 and younger are required to show documentation of a meningitis A 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. This includes a Tb Attestation Statement and Tb testing. 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.

***ALL TB TESTING (skin tests or blood tests) MUST BE PERFORMED IN THE U.S.**

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: _____

*If positive skin test result, IGRA required within 3 months prior to matriculation.

OR

- a. IGRA (Tspot or Quantiferon TB Gold) blood test within 3 months prior to matriculation:

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

*If positive IGRA result, Chest X-Ray within 3 months prior to matriculation and UAB TB High Risk 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: _____ (treatment only required if chest x-ray positive)

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: ____/____/____