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VISITING MEDICAL STUDENT IMMUNIZATION DOCUMENTATION

NAME:_____ _____ GENDER: ☐ MALE ☐ FEMALE

DATE OF BIRTH: _____/_____/_____ TIME PERIOD OF YOUR VISIT: _____

ADDRESS: _____CELL PHONE: _____

_____EMAIL:_____

THE BELOW INFORMATION IS REQUIRED. INCOMPLETE FORMS WILL DELAY YOUR START DATE.

PHYSICIAN/CRNP/EMPLOYEE HEALTH RN MUST COMPLETE AND SIGN BELOW.

A. Chicken Pox/Varicella: Proof of immunity will mean two doses of varicella or serologic evidence of immunity.

Immunization dates: #1 _____ # 2 _____

Titer date: _____ Result (copy must be attached): ☐ Immune ☐ Not Immune

B. Rubella: Proof of immunity to German Measles will mean one dose of the rubella vaccine or serologic evidence of the disease.

Immunization date: _____

Titer date: _____ Result (copy must be attached): ☐ Immune ☐ Not Immune

C. Rubeola: Proof of immunity to measles means two doses of live vaccine (after 1968) administered on or after the first birthday, separated by at least one month, or serologic evidence of immunity.

Immunization dates: #1 _____ # 2 _____

Titer date: _____ Result (copy must be attached): ☐ Immune ☐ Not Immune

D. Mumps: Proof of mumps immunity means two doses of mumps vaccine administered on or after the 1st birthday or serologic evidence of immunity.

Immunization dates: #1 _____ #2 _____

Titer date: _____ Result (copy must be attached): ☐ Immune ☐ Not Immune

E. Tuberculosis Screen: IGRA (Interferon-Gamma Release Assays) blood test is required.

Date:____/____/____(must be within 3 months) **Result (copy must be attached):** ☐ Positive ☐ Negative ☐ Indeterminate

If IGRA is positive, a chest x-ray is required. Date:____/____/____(must be within 6 months; **attach a copy of the report)**

F. Influenza Vaccination from current or most recent season (PRIOR TO ARRIVAL):

Date of administration: _____ Lot #_____ Manufacturer: _____ Exp _____

G. Pertussis: Proof of immunity will mean documentation of the Tdap vaccine (tetanus, diphtheria, pertussis or ADACEL).

Immunization date: _____ (must be post 2005)

H. Hepatitis B: Immunization dates: #1____/____/____ #2____/____/____ #3____/____/____ **AND** HBsAb titer date:____/____/____
☐ Immune ☐ Not Immune **(must attach titer results)**

MD/CRNP: _____(Print) Signature: _____ Date: _____

Address: _____

Phone:_____

Revised: 06/22/2015