UC RIVERSIDE | School of Medicine

Incoming Student Immunization Requirements

Name: _____ Student ID#: _____

Birth date: _____ E-Mail: _____

MMR (Measles, Mumps, Rubella) *– IgG Quantitative titers that reflect serologic proof of immunity for Measles, Mumps and Rubella. Copies of titer results must be attached and must reflect numeric antibody results.*
NOTE: Comprehensive (childhood) immunization records, including two (2) doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and one (1) dose of Rubella, must accompany negative titer results with administered booster.

Measles Serology: Specify the date and result of IgG serologic blood test for Measles immunity. *If the result is **negative**, a booster vaccine after the date of the blood test is required.*

Test Date: _____ Result: _____positive _____negative

Measles: *(only required if Measles [Rubeola] titer is negative)* Specify the date of Measles immunization.

Date of Booster: _____

Rubella Serology: Specify the date and result of IgG serologic blood test for Rubella immunity. *If the result is **negative**, a booster vaccine after the date of the blood test is required*.

Test Date: _____ Result: _____positive _____negative

Rubella (*only required if Rubella titer is negative*) Specify the date of Rubella immunization.

Date of Booster: _____

Mumps Serology: Specify the date and result of IgG serologic blood test for Mumps immunity. *If the result is **negative**, a booster vaccine after the date of the blood test is required*.

Test Date: _____ Result: _____positive _____negative

Mumps (*only required if Mumps titer is negative*) Specify the date of Mumps immunization.

Date of Booster: _____

Measles, Mumps, and Rubella (MMR) (*satisfies requirement for Measles, Mumps, and Rubella if any of the titers were negative*). Specify the date of MMR immunization.

Date of Booster: _____

Varicella *– – IgG Quantitative titer that reflects serologic proof of immunity for Varicella. A copy of titer results must be attached and must reflect numeric antibody results.*
NOTE: Proof of two-dose reimmunization must accompany negative titer results.

Varicella Serology: Specify the date and result of IgG serologic blood test for Varicella immunity. *If the result is **negative**, a new immunization series after the date of the blood test is required*.

Test Date: _____ Result: _____positive _____negative

Varicella (Chicken Pox) (*only required if Varicella titer is negative*) Specify the date of Varicella immunizations.

Two new doses required
Date for Dose 1: _____
Date for Dose 2: _____

Tetanus, Diptheria and Pertussis *– One (1) dose of adult Tdap vaccine. If last Tdap is more than 10 years old, new vaccination is required. Copy of immunization record must be attached.*

Tetanus, Diptheria and Pertussis (Tdap) Immunizations: Specify the date on which the dose was given:

Date of Most Recent Immunization: _____

Hepatitis B *– QUANTITATIVE Hepatitis B Surface Antibody titer that reflects serologic proof of immunity for Hepatitis B. If negative, complete a second Hepatitis B series (three (3) doses of Hepatitis B vaccine or two (2) doses of Heplisav-V vaccine) followed by a repeat Quantitative Surface Antibody titer. If Surface Antibody titer is negative after secondary series, additional testing including Hepatitis B Surface Antigen should be performed. Copies of titer results must be attached and must reflect numeric antibody results.*

Quantitative Hepatitis B Surface Antibody Serology:
Specify the date and result of Hepatitis B surface antibody titer.

Test Date: _____ Result: _____positive _____negative

Secondary Hepatitis B Series: (*only required if titer shows no response to primary series*)
Specify the date that each dose of Hepatitis B vaccine was given. Two or three doses are required as indicated above.

Date for Dose 4: _____
Date for Dose 5: _____
Date for Dose 6: _____

Quantitative Hepatitis B Surface Antibody Serology: (*only required if secondary series was required*)
Specify the date and result of Hepatitis B surface antibody titer.

Test Date: _____ Result: _____positive _____negative

Hepatitis B Non-Responder: (*If Hepatitis B Surface Antibody is negative after Primary and Secondary series*)
Specify the date and result of Hepatitis B surface antigen AND core antibody titers.
Copies of titer results must be attached.

Surface Antigen Test Date: _____ Result: _____positive _____negative

Core Antibody Test Date: _____ Result: _____positive _____negative

Chronic Active Hepatitis B: *Copies of titer results must be attached.*

Hepatitis B Surface Antigen Date: _____

Hepatitis B Viral Load Date: _____

Infectious disease status reviewed and updated (by signing below, clinician certifies this to be true).

Signature of Clinician: _____ Date: _____

Name and Title: _____ Phone: _____

Address: _____