UC RIVERSIDE | School of Medicine

Incoming Student Immunization Requirements

Health Screening Requirements: Immunization/Infectious Disease Status:
NOTE: Comprehensive (childhood) immunization records must accompany titer results.

Name: _____ Student ID#: _____

Birth date: _____ E-Mail: _____

MMR (Measles, Mumps, Rubella) *– Two (2) doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and one (1) dose of Rubella; in addition, serologic proof of immunity for Measles, Mumps and Rubella, or proof of recent boosters.*

Measles Serology: Specify the date and result of 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 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 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 *– Two (2) doses of Varicella vaccine, plus serologic proof of immunity, or proof of recent re-vaccination.*

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

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

Date of Most Recent Immunization: _____

Hepatitis B *– Three (3) doses of Hepatitis B vaccine, plus a QUANTITATIVE Hepatitis B Surface Antibody (titer) preferably drawn 4 – 8 weeks after 3rd dose. If negative, complete a second Hepatitis B series followed by a repeat titer. If Hepatitis B Surface Antibody is negative after secondary series, additional testing including Hepatitis B Surface Antigen should be performed.*

Primary Hepatitis B Series: Specify the date that each dose of Hepatitis B vaccine was given. Three doses are required.

Date for Dose 1: _____
Date for Dose 2: _____
Date for Dose 3: _____

Quantitative Hepatitis B Surface Antibody Serology:
PLEASE NOTE: This is required IN ADDITION to Hepatitis B Immunization history)
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. Three doses are required.

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 results must be attached.

Surface Antigen Test Date: _____ Result: _____positive _____negative

Core Antibody Test Date: _____ Result: _____positive _____negative

Chronic Active Hepatitis B: *Copies of 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: _____