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: ____________________________________________________________________