



AAMC Standardized Immunization Form

Last Name:	First Name:	Middle Initial:
DOB:	Street Address:	
Medical School:	City:	
Cell Phone:	State:	
Primary Email:	ZIP Code:	
Student ID:		

MMR (Measles, Mumps, Rubella) – 2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and (1) dose of Rubella; or serologic proof of immunity for Measles, Mumps and/or Rubella. Choose only one option.				Copy Attached	
Option 1	Vaccine	Date			
MMR -2 doses of MMR vaccine	MMR Dose #1	_/_/___	<input type="checkbox"/>		
	MMR Dose #2	_/_/___			
Option 2	Vaccine or Test	Date			
Measles -2 doses of vaccine or positive serology	Measles Vaccine Dose #1	_/_/___	Serology Results		
	Measles Vaccine Dose #2	_/_/___	Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Serologic Immunity (IgG, antibodies, titer)	_/_/___	Quantitative Titer Results:	_____ IU/ml	
Mumps -2 doses of vaccine or positive serology	Mumps Vaccine Dose #1	_/_/___	Serology Results		
	Mumps Vaccine Dose #2	_/_/___	Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Serologic Immunity (IgG, antibodies, titer)	_/_/___	Quantitative Titer Results:	_____ IU/ml	
Rubella -1 dose of vaccine or positive serology			Serology Results		
	Rubella Vaccine	_/_/___	Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Serologic Immunity (IgG, antibodies, titer)	_/_/___	Quantitative Titer Results:	_____ IU/ml	
Tetanus-diphtheria-pertussis – One (1) dose of adult Tdap. If last Tdap is more than 10 years old, provide date of last Td and Tdap					
		Tdap Vaccine (Adacel, Boostrix, etc)	_/_/___	<input type="checkbox"/>	
		Td Vaccine (if more than 10 years since last Tdap)	_/_/___		
Varicella (Chicken Pox) -2 doses of vaccine or positive serology					
		Varicella Vaccine #1	_/_/___	Serology Results	
		Varicella Vaccine #2	_/_/___	Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
				Quantitative Titer Results:	_____ IU/ml
Influenza Vaccine -- 1 dose annually each fall					
Second flu vaccine is for updating your form only				Date	
		Flu Vaccine		_/_/___	
		Flu Vaccine		_/_/___	



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Hepatitis B Vaccination --3 doses of <i>Engerix-B, Recombivax</i> or <i>Twinrix</i> or 2 doses of <i>Heplisav-B</i> followed by a QUANTITATIVE Hepatitis B Surface Antibody (titer) preferably drawn 4-8 weeks after 3 rd dose. If negative, complete a second Hepatitis B series followed by a repeat titer. If Hepatitis B Surface Antibody is negative after a secondary series, additional testing including Hepatitis B Surface Antigen should be performed. See: http://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf for more information. Documentation of Chronic Active Hepatitis B is for rotation assignments and counseling purposes only.				Copy Attached
Primary Hepatitis B Series <small>Heplisav-B only requires two doses of vaccine followed by antibody testing</small>	3-dose vaccines (<i>Engerix-B, Recombivax, Twinrix</i>) 2-dose vaccines (<i>Heplisav-B</i>)	3 Dose Series	2 Dose Series	<input type="checkbox"/>
	Hepatitis B Vaccine Dose #1	_ / _ / _	_ / _ / _	
	Hepatitis B Vaccine Dose #2	_ / _ / _	_ / _ / _	
	Hepatitis B Vaccine Dose #3	_ / _ / _		
	QUANTITATIVE Hep B Surface Antibody	_ / _ / _	_____ IU/ml	
Secondary Hepatitis B Series <u>Only If no response to primary series</u> <small>Heplisav-B only requires two doses of vaccine followed by antibody testing</small>		3 Dose Series	2 Dose Series	<input type="checkbox"/>
	Hepatitis B Vaccine Dose #4	_ / _ / _	_ / _ / _	
	Hepatitis B Vaccine Dose #5	_ / _ / _	_ / _ / _	
	Hepatitis B Vaccine Dose #6	_ / _ / _		
	QUANTITATIVE Hep B Surface Antibody	_ / _ / _	_____ IU/ml	
Hepatitis B Vaccine Non-responder <small>(If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)</small>	Hepatitis B Surface Antigen	_ / _ / _	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/>
	Hepatitis B Core Antibody	_ / _ / _	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Chronic Active Hepatitis B	Hepatitis B Surface Antigen	_ / _ / _	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/>
	Hepatitis B Viral Load	_ / _ / _	_____ copies/ml	
Additional Documentation				
<i>Some institutions may have additional requirements depending upon rotation, school requirements or state law. Examples include meningitis vaccine which is mandated in some states if you live in dormitory style housing. If you will be participating in an international experience you may also be required to provide proof of vaccines such as yellow fever or typhoid. Respiratory Fit Testing, etc</i>				
Vaccination, Test or Examination	Date	Result or Interpretation		
Physical Exam (if required)	_ / _ / _			<input type="checkbox"/>
Respiratory Fit Testing	_ / _ / _			<input type="checkbox"/>
	_ / _ / _			
	_ / _ / _			
	_ / _ / _			
	_ / _ / _			
	_ / _ / _			
	_ / _ / _			



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TUBERCULOSIS SCREENING – Results of last (2) TSTs (PPDs) or (1) IGRA blood test are required **regardless** of prior BCG status. If you have a history of a positive TST (PPD) ≥ 10 mm or IGRA please supply information regarding any evaluation and/or treatment below. You only need to complete ONE section.

Skin test or IGRA results should not expire during proposed elective rotation dates
or
must be updated with the receiving institution prior to rotation.

Tuberculosis Screening History

Please complete only one TB section based on your history	Section A		Date Placed	Date Read	Result	Interpretation	
	Negative Skin or Blood Test History	TST #1	___/___/___	___/___/___	___ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	
		TST #2	___/___/___	___/___/___	___ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	
		TST #3	___/___/___	___/___/___	___ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	
		TST #4	___/___/___	___/___/___	___ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	
	Last two skin test or IGRAs required			Date	Result		
	T-spots or QuantiFERON TB Gold blood tests for tuberculosis	QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>	___/___/___		<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
	Use additional rows as needed	QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>	___/___/___		<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
		QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>	___/___/___		<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
		QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>	___/___/___		<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
	Section B		Date Placed	Date Read	Result		
	History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test	Positive TST	___/___/___	___/___/___	___ mm		
				Date	Result		
			QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>	___/___/___		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
			Chest X-ray	___/___/___		_____	
			Treated for latent TB?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			If treated for latent TB, list medications taken:				
			Total Duration of treatment latent TB?			___ Months	
		Date of Last Annual TB Symptom Questionnaire			___/___/___		
	Section C				Date		
	History of Active Tuberculosis	Date of Diagnosis			___/___/___		
		Date of Treatment Completed			___/___/___		
		Date of Last Annual TB Symptom Questionnaire			___/___/___		
		Date of Last Chest X-ray			___/___/___		



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Additional Information

MUST BE COMPLETED BY YOUR HEALTH CARE PROVIDER OR INSTITUTIONAL DESIGNEE:

Authorized Signature:		Date: ___/___/___
Printed Name:		Office Use Only
Title:		
Address Line 1:		
Address Line 2:		
City:		
State:		
Zip:		
Phone:	() _____ - _____	
Ext:	_____	
Fax:	() _____ - _____	
Email Contact:		

*Sources:

- [Hepatitis B In: Centers for Disease Control and Prevention. Epidemiology and Prevention of Vaccine-Preventable Diseases. Hamborsky J, Kroger A, Wolfe S, eds. 13th ed. Washington D.C. Public Health Foundation, 2015](#)
- [Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices \(ACIP\), MMWR, Vol 60\(7\):1-45](#)
- [CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management, MMWR, Vol 62\(RR10\):1-19](#)
- [Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices, MMWR Vol 67\(1\):1-31](#)