



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:	Last 4 SS#:	

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

Option1	Vaccine	Date	
MMR <i>-2 doses of MMR vaccine</i>	MMR Dose #1	_/_/____	
	MMR Dose #2	_/_/____	
Option 2	Vaccine or Test	Date	
Measles <i>-2 doses of vaccine or positive serology</i>	Measles Vaccine Dose #1	_/_/____	
	Measles Vaccine Dose #2	_/_/____	
	Serologic Immunity (IgG, antibodies, titer)	_/_/____	<input type="checkbox"/> Copy Attached
Mumps <i>-2 doses of vaccine or positive serology</i>	Mumps Vaccine Dose #1	_/_/____	
	Mumps Vaccine Dose #2	_/_/____	
	Serologic Immunity (IgG, antibodies, titer)	_/_/____	<input type="checkbox"/> Copy Attached
Rubella <i>-1 dose of vaccine or positive serology</i>	Rubella Vaccine	_/_/____	
	Serologic Immunity (IgG, antibodies, titer)	_/_/____	<input type="checkbox"/> Copy Attached

Hepatitis B Vaccination --3 doses of vaccine followed by 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 a secondary series, additional testing including Hepatitis B Surface Antigen should be performed. See: <http://www.cdc.gov/mmwr/pdf/rr/r6210.pdf> for more information.

Documentation of Chronic Active Hepatitis B is for rotation assignments and counseling purposes only.

	Vaccine or Test	Date	
Primary Hepatitis B Series	Hepatitis B Vaccine Dose #1	_/_/____	
	Hepatitis B Vaccine Dose #2	_/_/____	
	Hepatitis B Vaccine Dose #3	_/_/____	
	QUANTITATIVE Hep B Surface Antibody	_/_/____	Result _____ mIU/ml
Secondary Hepatitis B Series <small>(If no response to primary series)</small>	Hepatitis B Vaccine Dose #4	_/_/____	
	Hepatitis B Vaccine Dose #5	_/_/____	
	Hepatitis B Vaccine Dose #6	_/_/____	
	QUANTITATIVE Hep B Surface Antibody	_/_/____	Result _____ mIU/ml
Hepatitis B Vaccine Non-responder <small>(If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)</small>	Hepatitis B Surface Antigen (if 2 nd titer negative)	_/_/____	<input type="checkbox"/> Copy Attached
	Hepatitis B Core Antibody (if 2 nd titer negative)	_/_/____	<input type="checkbox"/> Copy Attached
Chronic Active Hepatitis B	Hepatitis B Surface Antigen	_/_/____	<input type="checkbox"/> Copy Attached
	Hepatitis B Viral Load	_/_/____	<input type="checkbox"/> Copy Attached

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

	Date
Tdap Vaccine (Adacel, Boostrix, etc)	_/_/____
Td Vaccine (if more than 10 years since last Tdap)	_/_/____



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 (Last, First, Middle Initial) (mm/dd/yyyy)

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.

Tuberculin Screening History

Please complete one TB section only	Section A		Date Placed	Date Read	Reading	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		
				Date	Result			
		Last two skin test or IGRAs required		IGRA Blood Test (Interferon gamma releasing assay)		___/___/___	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> Copy Attached
		Use additional rows as needed		IGRA Blood Test (Interferon gamma releasing assay)		___/___/___	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> Copy Attached
			IGRA Blood Test (Interferon gamma releasing assay)		___/___/___	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> Copy Attached	
	Section B		Date Placed	Date Read	Reading	Interpretation		
	History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test	Positive TST	___/___/___	___/___/___	___ mm			
				Date	Result			
		Positive IGRA Blood Test		___/___/___	___/___/___	___ IU	<input type="checkbox"/> Copy Attached	
		Chest X-ray		___/___/___	___/___/___		<input type="checkbox"/> Copy Attached	
		Prophylactic Medications for latent TB taken?					<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Total Duration of prophylaxis?					___ Months	
Date of Last Annual TB Symptom Questionnaire (if applicable)				___/___/___	<input type="checkbox"/> Copy Attached			
Section C				Date				
History of Active Tuberculosis	Date of Diagnosis			___/___/___				
	Date of Treatment Completed			___/___/___	<input type="checkbox"/> Copy Attached			
	Date of Last Annual TB Symptom Questionnaire (if applicable)			___/___/___	<input type="checkbox"/> Copy Attached			
	Date of Last Chest X-ray			___/___/___	<input type="checkbox"/> Copy Attached			

Varicella (Chicken Pox) -2 doses of vaccine or positive serology

	Date	
Varicella Vaccine #1	___/___/___	
Varicella Vaccine #2	___/___/___	
Serologic Immunity (IgG, antibodies, titer)	___/___/___	<input type="checkbox"/> Copy Attached



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Influenza Vaccine -- 1 dose annually each fall			
	Flu Vaccine	__/__/__	<input type="checkbox"/> Copy Attached
	Flu Vaccine	__/__/__	<input type="checkbox"/> Copy Attached
Additional Information:			

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

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

*Sources:

1. [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](#)
2. [Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices \(ACIP\), MMWR, Vol 60\(7\):1-45](#)
3. [CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management, MMWR, Vol 62\(RR10\):1-19](#)