



Immunization Packet Instructions

All forms and uploads must be completed at <https://redcap.link/2y54qcyh>

1  Ask your healthcare provider to fill out this immunization packet

2  Upload your signed, completed packet and any supporting documentation, if applicable (ex: labs, blood work, x-ray report)

Clinical students (category 1) immunization requirements apply to students who will see patients or clients during the course of their program and may be exposed to blood or body fluids. Not sure of your category? Reach out to your program.

Required:

COVID-19: bivalent dose or booster
Measles Mumps Rubella
Hepatitis B, including labs for immunity
Adult Tdap
Tuberculosis screening
Varicella
Annual flu

May be required (see immunization form for details):

Meningitis ACYW
Meningitis B



Student to complete (please print or type)

Last name _____	First name _____	DOB (mm/dd/yyyy) _____
RUID or A number _____	Email _____	Cell phone _____
School/Program _____		Grad year _____

Healthcare provider to complete (please print or type)

Measles, Mumps, Rubella (MMR) – Complete option A, B, or C to fulfill this requirement			
Option A: MMR vaccine doses First dose on or after first birthday and a second dose at least 28 days after.	Vaccine/Titer	Date (mm/dd/yyyy)	Result
	MMR dose 1	____/____/____	
	MMR dose 2	____/____/____	
Option B: MMR serological immunity To satisfy this option, blood tests must demonstrate immunity to measles, mumps, and rubella. LAB REPORTS ARE REQUIRED AND MUST BE UPLOADED AS AN ATTACHMENT	Measles (<i>Rubeola</i>) titer	____/____/____	<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune
	Mumps titer	____/____/____	<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune
	Rubella titer	____/____/____	<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune
Option C: Measles, Mumps and Rubella immunizations if given separately. Doses may be entered individually in this section. <i>DO NOT RE-ENTER DOSES IF LISTED ABOVE</i>	Measles dose 1	____/____/____	
	Measles dose 2	____/____/____	
	Mumps dose 1	____/____/____	
	Mumps dose 2	____/____/____	
	Rubella dose 1	____/____/____	

Hepatitis B – Complete Section A and B			
Section A: Hep B antibody test To satisfy the requirement, you must supply a QUANTITATIVE Hep B Surface Antibody test showing immunity to Hepatitis B. LAB REPORTS ARE REQUIRED AND MUST BE UPLOADED AS AN ATTACHMENT	Test	Date (mm/dd/yyyy)	Lab Results
	<u>Quantitative</u> Hep B Surface Antibody	____/____/____	<input type="checkbox"/> Immune (≥10 mIU/mL) <input type="checkbox"/> Non-immune (<i>If you are non-immune you must complete the Hepatitis B Surface Antigen test**</i>) <input type="checkbox"/> Lab Report Attached
**Hep B Surface antigen test <i>We recommend submitting a Hep B Surface Antigen in case the quantitative Hep B Surface Antibody does not demonstrate immunity.</i>	Hep B Surface Antigen	____/____/____	<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Lab Report Attached
Section B: Hep B vaccine doses If starting the series, at least one dose is required prior to enrollment.	Vaccine	Date (mm/dd/yyyy)	Manufacturer
	Hep B dose 1	____/____/____	<input type="checkbox"/> Engerix <input type="checkbox"/> Twinrix <input type="checkbox"/> Heplisav
	Hep B dose 2	____/____/____	<input type="checkbox"/> Engerix <input type="checkbox"/> Twinrix <input type="checkbox"/> Heplisav
	Hep B dose 3	____/____/____	<input type="checkbox"/> Engerix <input type="checkbox"/> Twinrix

COVID-19 – A primary series AND a booster dose			
All doses must be FDA or WHO-approved.	Vaccine	Date (mm/dd/yyyy)	Manufacturer
	Dose 1	____/____/____	
	Dose 2	____/____/____	
	Most recent booster	____/____/____	

Last name _____ First name _____ DOB (mm/dd/yyyy) _____ RUID or A number _____

Adult Tdap (Tetanus, Diphtheria & Acellular Pertusis) _____ / _____ / _____ Adacel Boostrix

Annual Influenza – List vaccination for the current flu season _____ / _____ / _____

Tuberculosis (TB) Screening – Complete option A or B to fulfill this requirement

<p>Option A: PPD (Mantoux) skin tests Required regardless of prior BCG vaccination. To complete this option: 2 step PPD (consisting of 2 PPDs placed 1-3 weeks apart and read 48-72 hours after placement) within the past 6 months of your enrollment date. Both tests must be < 10mm.</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 35%;">PPD placed</th> <th style="width: 35%;">PPD read</th> <th style="width: 15%;">Induration</th> </tr> </thead> <tbody> <tr> <td>PPD 1</td> <td>____/____/____</td> <td>____/____/____</td> <td>____ mm</td> </tr> <tr> <td>PPD 2</td> <td>____/____/____</td> <td>____/____/____</td> <td>____ mm</td> </tr> </tbody> </table>		PPD placed	PPD read	Induration	PPD 1	____/____/____	____/____/____	____ mm	PPD 2	____/____/____	____/____/____	____ mm
	PPD placed	PPD read	Induration										
PPD 1	____/____/____	____/____/____	____ mm										
PPD 2	____/____/____	____/____/____	____ mm										

If PPD is positive (≥ 10mm), is the student free of TB symptoms? Yes No
 If yes, list date of the positive PPD and induration. ____/____/____, ____ mm
 Was the student treated? Yes No
 If yes, for how long was the student treated and with which medication? _____
*If PPD is positive: option B or a chest x-ray** must be completed.*

<p>Option B: FDA approved blood test To complete this option, you must supply an FDA approved blood test showing absence of TB infection within the past 6 months of your enrollment date. Lab report must be attached. <i>If your TB Blood test result is positive, a chest x-ray** must be completed.</i></p>	<p>Blood test Date: ____/____/____ Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive Type: <input type="checkbox"/> QuantiFERON Gold <input type="checkbox"/> T-Spot <input type="checkbox"/> Lab Report attached</p>
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<p>**Chest x-ray result If you did NOT have a positive PPD or positive blood test, do NOT complete this option <i>To complete this option a chest x-ray within the past 6 months must be <u>normal</u>, and <u>report must be attached</u>.</i></p>	<p>Chest x-ray Date: ____/____/____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____ <input type="checkbox"/> Report attached</p>
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Varicella (Chicken Pox) – Complete option A or B to fulfill this requirement

	Vaccine/Titer	Date (mm/dd/yyyy)	Result
<p>Option A: Varicella vaccine doses First dose on or after your first birthday and a second dose at least 28 days apart</p>	Varicella dose 1 _____/_____/_____ Varicella dose 2 _____/_____/_____		
<p>Option B: Varicella serologic immunity To satisfy this option, you must submit a blood test demonstrating immunity to varicella. LAB REPORTS ARE REQUIRED AND MUST BE UPLOADED AS AN ATTACHMENT</p>	<p>Varicella Titer _____/_____/_____</p>		<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Lab Report attached

Healthcare provider name (<i>print</i>):	(<i>sign</i>):	Date	Practice stamp
NPI:			