



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 -2 doses of MMR vaccine	MMR Dose #1	___/___/___	
	MMR Dose #2	___/___/___	
Option 2	Vaccine or Test	Date	
Measles -2 doses of vaccine or positive serology	Measles Vaccine Dose #1	___/___/___	
	Measles Vaccine Dose #2	___/___/___	
	Serologic Immunity (IgG, antibodies, titer)	___/___/___	
Mumps -2 doses of vaccine or positive serology	Mumps Vaccine Dose #1	___/___/___	
	Mumps Vaccine Dose #2	___/___/___	
	Serologic Immunity (IgG, antibodies, titer)	___/___/___	
Rubella -1 dose of vaccine or positive serology	Rubella Vaccine	___/___/___	
	Serologic Immunity (IgG, antibodies, titer)	___/___/___	

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/rr6103.pdf> for more information.

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

		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 ☐ Copy Attached
Secondary Hepatitis B Series (If no response to primary series)	Hepatitis B Vaccine Dose #4	___/___/___	
	Hepatitis B Vaccine Dose #5	___/___/___	
	Hepatitis B Vaccine Dose #6	___/___/___	
	QUANTITATIVE Hep B Surface Antibody	___/___/___	Result _____ mIU/ml ☐ Copy Attached
Hepatitis B Vaccine Non-responder (If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)	Hepatitis B Surface Antigen (if 2 nd titer negative)	___/___/___	☐ Copy Attached
	Hepatitis B Core Antibody (if 2 nd titer negative)	___/___/___	☐ Copy Attached
Chronic Active Hepatitis B	Hepatitis B Surface Antigen	___/___/___	☐ Copy Attached
	Hepatitis B Viral Load	___/___/___	☐ 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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Name: _____ Date of Birth: _____
 (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 Last two skin test or IGRAs required Use additional rows as needed	TST #1	___/___/___	___/___/___	___ mm	☐ Pos ☐ Neg ☐ Equiv
		TST #2	___/___/___	___/___/___	___ mm	☐ Pos ☐ Neg ☐ Equiv
		TST #3	___/___/___	___/___/___	___ mm	☐ Pos ☐ Neg ☐ Equiv
			Date	Result		
		IGRA Blood Test (Interferon gamma releasing assay)	___/___/___	☐ Negative ☐ Indeterminate	☐ Copy Attached	
		IGRA Blood Test (Interferon gamma releasing assay)	___/___/___	☐ Negative ☐ Indeterminate	☐ Copy Attached	
		IGRA Blood Test (Interferon gamma releasing assay)	___/___/___	☐ Negative ☐ Indeterminate	☐ 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	☐ Copy Attached	
		Chest X-ray	___/___/___		☐ Copy Attached	
		Prophylactic Medications for latent TB taken?				☐ Yes ☐ No
		Total Duration of prophylaxis?				___ Months
		Date of Last Annual TB Symptom Questionnaire (if applicable)				___/___/___ ☐ Copy Attached
	Section C		Date			
	History of Active Tuberculosis	Date of Diagnosis		___/___/___		
		Date of Treatment Completed		___/___/___		☐ Copy Attached
		Date of Last Annual TB Symptom Questionnaire (if applicable)		___/___/___		☐ Copy Attached
Date of Last Chest X-ray		___/___/___		☐ Copy Attached		

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

	Date	
Varicella Vaccine #1	___/___/___	
Varicella Vaccine #2	___/___/___	
Serologic Immunity (IgG, antibodies, titer)	___/___/___	☐ Copy Attached



Influenza Vaccine --1 dose annually each fall			
	Flu Vaccine	___/___/___	☐ Copy Attached
	Flu Vaccine	___/___/___	☐ Copy Attached
Additional Information:			

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

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. [Updated CDC Recommendations for the Management of Hepatitis B Virus–Infected Health-Care Providers and Students, MMWR Vol 61\(RR03\):1-12.](#)