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	___/___/____			☐
	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:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG antibody 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:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG antibody titer)	___/___/_____	Quantitative Titer Results:	_____ IU/ml	
Rubella *-1 dose of vaccine or positive serology*			**Serology Results**		☐
	Rubella Vaccine	___/___/_____	Qualitative Titer Results:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG antibody 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 dates of last Td and Tdap*					
	Tdap Vaccine (Adacel, Boostrix, etc)	___/___/_____			☐
	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:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG antibody titer)	___/___/___	Quantitative Titer Results:	_____ IU/ml	
Influenza Vaccine - *1 dose annually each fall*					
Date of last dose		**Date**			☐
	Flu Vaccine	___/___/____			

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Hepatitis B Vaccination - *3 doses of Engergix-B, Recombivax or Twinrix vaccines or 2 doses of Heplisav-B vaccine followed by a **QUANTITATIVE** Hepatitis B Surface Antibody test drawn 4-8 weeks after last vaccine dose. A test titer ≥10mIU/mL is positive for immunity. If the test result is negative, repeat another Hepatitis B vaccine series followed by a repeat test titer.If the Hepatitis B Surface Antibody test is negative after the repeatvaccine series, a "non-responder" status is assigned. See: http://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf for more information.*				Copy Attached
Primary Hepatitis B Series Heplisav-B only requires two doses of vaccine followed by antibody testing	3-dose vaccines (Energix-B, Recombivax, Twinrix) 2-dose vaccines (Heplisav-B)	**3 Dose Series**	**2 Dose Series**	☐
	Hepatitis B Vaccine Dose #1	___/___/_____	___/___/_____	
	Hepatitis B Vaccine Dose #2	___/___/_____	___/___/_____	
	Hepatitis B Vaccine Dose #3	___/___/_____		
	QUANTITATIVE Hep B Surface Antibody Test	___/___/_____	_____ mIU/ml	
Repeat Hepatitis B Series *Only If no response to primary series* Heplisav-B only requires two doses of vaccine followed by antibody testing		**3 Dose Series**	**2 Dose Series**	☐
	Hepatitis B Vaccine Dose #4	___/___/_____	___/___/_____	
	Hepatitis B Vaccine Dose #5	___/___/_____	___/___/_____	
	Hepatitis B Vaccine Dose #6	___/___/_____		
	QUANTITATIVE Hep B Surface Antibody Test	___/___/_____	_____ mIU/ml	
Hepatitis B Vaccine Non-responder	If the Hepatitis B Surface Antibody test is negative (titer less than 10 mIU/mL) after a primary and repeat vaccine series, vaccine non-responders should be counseled and evaluated appropriately. Certain institutions may request signing an "acknowledgement of non-responder status" document before clinical placements.			☐
Additional Documentation				
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.*				

Vaccination, Test or Examination	**Date**	**Result or Interpretation**	
Physical Exam (if required)	___/___/____		☐
	___/___/____		
	___/___/____		
	___/___/____		
	___/___/____		
	___/___/____		
	___/___/____		
	___/___/____		

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TUBERCULOSIS (TB) SCREENING – *All U.S. healthcare personnel are screened pre-placement for TB. Results of the last (2) TB Skin Tests (TSTs)) or (1) IGRA blood test are required* ***regardless*** *of prior BCG status. The 2-step TST protocol must have been placed within the past 12 months prior to clinical duties, and must have been performed in the U.S. The second TST must be placed at least 1 week after the first TST read date. If you have a history of a positive TST (PPD)≥10mm or a positive IGRA blood test, please supply information regarding any evaluation and/or treatment below. You only need to complete ONE section, A or B.*

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

History of Negative TB Skin Test or Blood Test

	Date Placed	Date Read	Result	Interpretation
TST #1	___/___/____	___/___/____	____ mm	❑ Pos ❑ Neg ❑ Equiv
TST #2	___/___/____	___/___/____	____mm	❑ Pos ❑ Neg ❑ Equiv

	Date	Result
T-spots or QuantiFERON TB Gold blood tests for tuberculosis		
QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)	___/___/____	❑ Positive ❑ Negative ❑ Indeterminate
QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)	___/___/____	❑ Positive ❑ Negative ❑ Indeterminate
Use additional rows as needed		

Section B

History of Positive Skin Test or Positive Blood Test

	Date Placed	Date Read	Result
Positive TST	___/___/____	___/___/___	_____ mm
		Date	**Result**
QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)		___/___/____	❑ Positive ❑ Negative ❑ Indeterminate
Chest X-ray*		___/___/____	*Provide documentation or result
Treated for **latent** TB infection (LTBI)?			❑ Yes ❑ No
Date of Last Annual TB Symptom Questionnaire			___/___/_____

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Additional Information

MUST BE SIGNED BY A LICENSED HEALTHCARE PROFESSIONAL OR DESIGNEE:

Healthcare Professional 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
4. Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices, MMWR Vol 67(1):1-31
5. Sosa LE, Nijie GL, Lobato MN, et.al. Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from National Tuberculosis Controllers Association and CDC, 2019. MMWR2019;68:439-443. https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s cid+mm6819a3 w

