



# AAMC Standardized Immunization Form

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

<b>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.</b> <i>Note: a 3<sup>rd</sup> dose of MMR vaccine may be advised during regional outbreaks of measles or mumps if original MMR vaccination was received in childhood.</i>				Copy Attached
Option 1	Vaccine	Date		
<b>MMR</b> -2 doses of MMR vaccine	MMR Dose #1			
	MMR Dose #2			
Option 2	Vaccine or Test	Date		
<b>Measles</b> -2 doses of vaccine or positive serology	Measles Vaccine Dose #1		<b>Serology Results</b>	
	Measles Vaccine Dose #2		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml
<b>Mumps</b> -2 doses of vaccine or positive serology	Mumps Vaccine Dose #1		<b>Serology Results</b>	
	Mumps Vaccine Dose #2		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml
<b>Rubella</b> -1 dose of vaccine or positive serology	Rubella Vaccine		<b>Serology Results</b>	
			Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml
Tetanus-diphtheria-pertussis – 1 dose of adult Tdap; if last Tdap is more than 10 years old, provide date of last Td or Tdap booster				
	Tdap Vaccine (Adacel, Boostrix, etc)			
	Td Vaccine or Tdap Vaccine booster (if more than 10 years since last Tdap)			
Varicella (Chicken Pox) - 2 doses of varicella vaccine or positive serology				
	Varicella Vaccine #1		<b>Serology Results</b>	
	Varicella Vaccine #2		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml
Influenza Vaccine --1 dose annually each fall				
		<b>Date</b>		
	Flu Vaccine			



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<b>Hepatitis B Vaccination</b> --3 doses of <i>Engerix-B, Recombivax</i> or <i>Twinrix</i> or 2 doses of <i>Heplisav-B</i> followed by a <b>QUANTITATIVE</b> Hepatitis B Surface Antibody (titer) preferably drawn 4-8 weeks after the last dose. If negative titer (<10 IU/ml) complete a second Hepatitis B series followed by a repeat titer. If Hepatitis B Surface Antibody titer is negative after a secondary series, additional testing including Hepatitis B Surface Antigen should be performed. See: <a href="http://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf">http://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf</a> for more information. Documentation of Chronic Active Hepatitis B is for rotation assignments and counseling purposes only.				Copy Attached
<b>Primary Hepatitis B Series</b>  <small>Heplisav-B only requires two doses of vaccine followed by antibody testing</small>	3-dose vaccines ( <i>Engerix-B, Recombivax, Twinrix</i> ) or 2-dose vaccine ( <i>Heplisav-B</i> )	<b>3 Dose Series</b>	<b>2 Dose Series</b>	
	Hepatitis B Vaccine Dose #1			
	Hepatitis B Vaccine Dose #2			
	Hepatitis B Vaccine Dose #3			
	<b>QUANTITATIVE</b> Hep B Surface Antibody		_____ IU/ml	
<b>Secondary Hepatitis B Series</b>  <u>Only If no response to primary series</u>  <small>Heplisav-B only requires two doses of vaccine followed by antibody testing</small>		<b>3 Dose Series</b>	<b>2 Dose Series</b>	
	Hepatitis B Vaccine Dose #4			
	Hepatitis B Vaccine Dose #5			
	Hepatitis B Vaccine Dose #6			
	<b>QUANTITATIVE</b> Hep B Surface Antibody		_____ IU/ml	
<b>Hepatitis B Vaccine Non-responder</b> <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	
	Hepatitis B Core Antibody		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
<b>Chronic Active Hepatitis B</b>	Hepatitis B Surface Antigen		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Hepatitis B Viral Load		_____ copies/ml	
<b>Additional Vaccines</b>				
<i>Some states and institutions may have additional vaccine requirements for students, health sciences personnel, and first responders depending upon assignment, school requirements or state law. Examples include meningitis vaccine which is mandated in some states for incoming students.</i>				
<b>Vaccination</b>	<b>Date</b>			
Meningococcal Vaccine ACWY				

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**CDC Recommendations: Preplacement (baseline) TUBERCULOSIS SCREENING AND TESTING of all health care personnel/ trainees consists of a TB symptom evaluation, a TB test (IGRA or TST), and an individual TB risk assessment. You only need to complete ONE section below: A or B or C.**

**Section A:** If you do not have a history of TB disease or LTBI (Latent Tuberculosis Infection), the results of a 2-step TST (Tuberculosis Skin Test), or TB IGRA (Interferon Gamma Release Assay) blood test are required, **regardless** of your prior BCG status. You should also check off the results of your individual baseline TB symptom evaluation and TB risk assessment questionnaire.

**Section B:** If you have a history of a positive TST (PPD)  $\geq 10$ mm or a positive IGRA, please supply information regarding further medical evaluation and treatment below.

**Section C:** History of active tuberculosis, diagnosis and treatment.

**Health Care Personnel with a baseline NEGATIVE Skin Test result or a NEGATIVE IGRA blood test and negative symptom evaluation will receive annual TB education; additional TB screening may be recommended by state or local health departments for certain occupational high risk groups.**

### Tuberculosis Screening History

	Section A	Date Placed	Date Read	Result	Interpretation	Copy Attached
Please complete only one TB section based on your history	<b>No history of prior TB Disease or LTBI</b> <small>Dates of the last 2-step TST or TB IGRA blood test are required</small>  <small>(IGRAs include QuantiFERON TB Gold Test, QuantiFERON TB Gold in-tube test, or T-spot TB Test)</small>	TST step #1		_____mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	
		TST step #2		_____mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	
			<b>Date</b>	<b>Result</b>		
		QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Release Assay)</small>		<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
		QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Release Assay)</small>		<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
		Individual TB Symptom Assessment		<input type="checkbox"/> Negative <input type="checkbox"/> Positive <small>(Medical follow-up needed)</small>		
	Individual TB Risk Assessment		<input type="checkbox"/> Negative <input type="checkbox"/> Positive <small>(Increased risk TB infection)</small>			
	<b>Section B</b>		<b>Date Placed</b>	<b>Date Read</b>	<b>Result</b>	
	<b>History of LTBI, Positive TB Skin Test, or Positive TB IGRA Blood Test</b>  <small>(IGRAs include QuantiFERON TB Gold Test, QuantiFERON TB Gold in-tube test, or T-spot TB Test)</small>	Positive TST			_____ mm	
			<b>Date</b>	<b>Result</b>		
		QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Release Assay)</small>		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
		Chest X-ray		_____		
		Treated for <b>latent</b> TB?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		If treated for <b>latent</b> TB, list medications taken:				
		Total Duration of treatment <b>latent</b> TB?		_____ Months		
Date of Last Annual TB Symptom Questionnaire						
<b>Section C</b>			<b>Date</b>			
<b>History of Active Tuberculosis</b>	Date of Diagnosis					
	Date of Treatment Completed					
	Date of Last Annual TB Symptom Questionnaire					
	Date of Last Chest X-ray					



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

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

\*Sources:

1. Kim DK, Hunter P. Advisory Committee on Immunization Practices: Recommended Immunization Schedule for Adults Aged 19 years or Older—United States, 2019. MMWR 2019; 68:115-118. <http://dx.doi.org/10.15585/mmwr.mm6805a5>.
2. [Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices \(ACIP\), MMWR 2011, Vol 60\(RR077\):1-45](#)
3. Schillie S, Harris A, Link-Gelles R. et al. Recommendations of the Advisory Committee on Immunization Practices for Use of a Hepatitis B Vaccine with a Novel Adjuvant. MMWR 2018;67:455-8. <https://doi.org/10.15585/mmwr.mm6715a5>.
4. Sosa LE, Njie GJ, Lobato MN, et al. Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019. MMWR 2019;68:439-443. <https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm>.
5. Centers for Disease Control and Prevention. Tuberculosis (TB) Screening, Testing, and Treatment of U.S. Health Care Personnel Frequently Asked Questions (FAQs). <https://www.cdc.gov/tb/topic/infectioncontrol/healthcarepersonnel-faq.htm>.