



# 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	
<b>MMR</b> <i>-2 doses of MMR vaccine</i>	MMR Dose #1	_/_/____	
	MMR Dose #2	_/_/____	
Option 2	Vaccine or Test	Date	
<b>Measles</b> <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
<b>Mumps</b> <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
<b>Rubella</b> <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 3<sup>rd</sup> 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	
<b>Primary Hepatitis B Series</b>	Hepatitis B Vaccine Dose #1	_/_/____	
	Hepatitis B Vaccine Dose #2	_/_/____	
	Hepatitis B Vaccine Dose #3	_/_/____	
	<b>QUANTITATIVE</b> Hep B Surface Antibody	_/_/____	Result _____ mIU/ml
<b>Secondary Hepatitis B Series</b> <small>(If no response to primary series)</small>	Hepatitis B Vaccine Dose #4	_/_/____	
	Hepatitis B Vaccine Dose #5	_/_/____	
	Hepatitis B Vaccine Dose #6	_/_/____	
	<b>QUANTITATIVE</b> Hep B Surface Antibody	_/_/____	Result _____ mIU/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 (if 2 <sup>nd</sup> titer negative)	_/_/____	<input type="checkbox"/> Copy Attached
	Hepatitis B Core Antibody (if 2 <sup>nd</sup> titer negative)	_/_/____	<input type="checkbox"/> Copy Attached
<b>Chronic Active Hepatitis B</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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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)  $\geq 10$ 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	<b>Section A</b>		<b>Date Placed</b>	<b>Date Read</b>	<b>Reading</b>	<b>Interpretation</b>		
	<b>Negative Skin or Blood Test History</b>	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		
				<b>Date</b>	<b>Result</b>			
		Last two skin test or IGRAs required		<b>IGRA Blood Test</b> (Interferon gamma releasing assay)		___/___/___	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> Copy Attached
		Use additional rows as needed		<b>IGRA Blood Test</b> (Interferon gamma releasing assay)		___/___/___	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> Copy Attached
	Use additional rows as needed		<b>IGRA Blood Test</b> (Interferon gamma releasing assay)		___/___/___	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> Copy Attached	
	<b>Section B</b>		<b>Date Placed</b>	<b>Date Read</b>	<b>Reading</b>	<b>Interpretation</b>		
	<b>History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test</b>	Positive TST	___/___/___	___/___/___	___ mm			
				<b>Date</b>	<b>Result</b>			
		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			
<b>Section C</b>				<b>Date</b>				
<b>History of Active Tuberculosis</b>	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

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



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**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
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<b>Influenza Vaccine -- 1 dose annually each fall</b>			
	Flu Vaccine	___/___/___	<input type="checkbox"/> Copy Attached
	Flu Vaccine	___/___/___	<input type="checkbox"/> Copy Attached
<b>Additional Information:</b>			

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

<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. [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](#)