# UCSF Visiting Student Immunization Form

**Student Name**

**Signature**

**Email address**

**School**

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## TB Skin Testing (must meet either A or B or C or D below)

**A. If you have a negative skin test**

If you have had annual TB skin testing: submit documentation of a PPD skin test within a year of rotation start date.

- **TEST:** mm reading ______ Date: _____/____/____

**B. If you have a past positive skin test:**

- **Positive skin test:** mm reading ______ Date: _____/____/____
- **Chest x-ray report:** required
  - x-ray results: 0 normal 0 abnormal
  - Date: _____/____/____
- **INH therapy taken:**
  - yes
  - no
  - Date started: ____/____/____ Date ended: ____/____/____
  - length of treatment ______ months

**C. QuantiFERON Gold test - Negative test results only**

There are instances where your provider might run a QuantiFERON lab test to establish PPD negative status: submit documentation of a QuantiFERON Gold test reported within current school year.

- **Negative QuantiFERON Date:** _____/____/____

**D. T-SPOT test results only**

Submit documentation of a negative T-SPOT test result reported within current school year.

- **Negative T-SPOT Date:** _____/____/____

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## Measles (rubeola)

1) **Positive measles titer**

- Date: _____/____/____

2) **2 MMR vaccinations**

- **Date:** Dose 1: MMR /____/____
- **Date:** Dose 2: MMR /____/____

## Mumps

1) **Positive mumps titer**

- Date: _____/____/____

2) **2 MMR vaccinations**

- **Date:** Dose 1: MMR /____/____
- **Date:** Dose 2: MMR /____/____

## Rubella (German measles)

1) **Positive rubella titer**

- Date: _____/____/____

2) **1 MMR vaccination**

- **Date:** Dose 1: MMR /____/____
- **Date:** Dose 2: MMR /____/____

## Varicella (History of disease is NOT sufficient)

1) **2 doses live varicella vaccine**

- **Date:** Dose 1 /____/____
- **Date:** Dose 2 /____/____

2) **Positive varicella titer**

- **Date:** /____/____
Hepatitis B: Titer REQUIRED

1a) Positive hepatitis B surface Ab titer
Date: _____/_____/

OR

2) Previous infection -
Need core antibody & surface antigen titers
Date: _____/_____/
Hep B core Ab titer
Date: _____/_____/
Hep B surface antigen

TB Questions - Required

TB Screening Questions REQUIRED

Have you ever received BCG?  θ yes  θ no  If yes: Year ______ Country _______________________

Have you traveled and/or lived overseas in the past year?  θ yes  θ no  If yes: Countries _______________________

Have you worked in a prison or homeless shelter in the past year?  θ yes  θ no

Have you entered a TB isolation room in the past year?  θ yes  θ no

Have you had exposure to a known case of TB in the past year?  θ yes  θ no

In the past six months have you experienced any of the following for greater than three weeks?

Excessive sweating at night  θ yes  θ no

Excessive weight loss  θ yes  θ no

Coughing up blood  θ yes  θ no

Excessive Fatigue  θ yes  θ no

Hoarseness  θ yes  θ no

Persistent coughing  θ yes  θ no

Persistent fever  θ yes  θ no

Tetanus/Diphtheria/Pertussis/ (Tdap) and Seasonal Flu Vaccine

Tdap (Tetanus Diphtheria Pertussis) Date: ___/___/___

Seasonal Flu Vaccine Date: ___/___/___
Must have most current vaccine (new vaccine available around September of each year)

I attest that all dates and immunizations listed above are correct and accurate.

Provider's Signature ___________________________________________  Date ____________________________
Physician, Nurse Practitioner, Physician's Assistant, or RN

Provider's name printed ___________________________________________  Phone number ________________________
Physician, Nurse Practitioner, Physician's Assistant, or RN

Revised 3/8/2016