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
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	___/___/_____	**Serology Results**		☐
	Measles Vaccine Dose #2	___/___/_____	Qualitative Titer Results:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG, antibodies, 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, antibodies, 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, antibodies, 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 date 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	
			Quantitative Titer Results:	_____ IU/ml	
Influenza Vaccine *--1 dose annually each fall*					
Second flu vaccine is for updating your form only		**Date**			☐
	Flu Vaccine	___/___/____			
	Flu Vaccine	___/___/____			

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Hepatitis B Vaccination *--3 doses of Engergix-B, Recombivax or Twinrix or 2 doses of Heplisav-B 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/rr6210.pdf for more information. Documentation of Chronic Active Hepatitis B is for rotation assignments and counseling purposes only.*				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	___/___/_____	_____ IU/ml	
Secondary 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	___/___/_____	_____ IU/ml	
Hepatitis B Vaccine Non-responder (If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)	Hepatitis B Surface Antigen	___/___/_____	❑ Positive ❑ Negative	☐
	Hepatitis B Core Antibody	___/___/_____	❑ Positive ❑ Negative	
Chronic Active Hepatitis B	Hepatitis B Surface Antigen	___/___/_____	❑ Positive ❑ Negative	☐
	Hepatitis B Viral Load	___/___/_____	_____ copies/ml	
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. Respiratory Fit Testing, etc*				

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

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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)≥10mm 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.

Tuberculosis Screening History

Please complete only one TB section based on your history

Section A

		Date Placed	Date Read	Result	Interpretation
Negative Skin or Blood Test History	**TST #1**	___/___/____	___/___/____	____ mm	❑ Pos ❑ Neg ❑ Equiv
	TST #2	___/___/____	___/___/____	____mm	❑ Pos ❑ Neg ❑ Equiv
	TST #3	___/___/____	___/___/____	____ mm	❑ Pos ❑ Neg ❑ Equiv
	TST #4	___/___/____	___/___/____	____ mm	❑ Pos ❑ Neg ❑ Equiv

Last two skin test or IGRAs required

T-spots or QuantiFERON TB Gold blood tests for tuberculosis

Use additional rows as needed

	Date	Result	
QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)	___/___/____	❑ Negative	❑ Indeterminate
QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)	___/___/____	❑ Negative	❑ Indeterminate
QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)	___/___/____	❑ Negative	❑ Indeterminate
QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)	___/___/____	❑ Negative	❑ Indeterminate

Section B

		Date Placed	Date Read	Result
History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test	Positive TST	___/___/____	___/___/___	_____ mm
			Date	**Result**
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)		___/___/____	❑ Positive ❑ Negative ❑ Indeterminate
	Chest X-ray		___/___/____	_____
	Treated for **latent** TB?			❑ Yes ❑ No
	If treated for **latent** TB, list medications taken:			
	Total Duration of treatment **latent** TB?			_____ Months
	Date of Last Annual TB Symptom Questionnaire			___/___/____

IGRAs include T-spots or QuantiFERON TB Gold blood tests for tuberculosis

Section C

		Date
History of Active Tuberculosis	Date of Diagnosis	___/___/____
	Date of Treatment Completed	___/___/____
	Date of Last Annual TB Symptom Questionnaire	___/___/____
	Date of Last Chest X-ray	___/___/____

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Additional Information

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

Authorized 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