# AAMC Standardized Immunization Form

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| | | | | | |
|---|---|---|---|---|---|
| **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** | |
|---|---|---|---|
| **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 | ___/___/_____ | |
| | Measles Vaccine Dose #2 | ___/___/_____ | |
| | Serologic Immunity (IgG, antibodies, titer) | ___/___/_____ | ❑ Copy Attached |
| **Mumps** *-2 doses of vaccine or positive serology* | Mumps Vaccine Dose #1 | ___/___/_____ | |
| | Mumps Vaccine Dose #2 | ___/___/_____ | |
| | Serologic Immunity (IgG, antibodies, titer) | ___/___/_____ | ❑ Copy Attached |
| **Rubella** *-1 dose of vaccine or positive serology* | Rubella Vaccine | ___/___/_____ | |
| | Serologic Immunity (IgG, antibodies, titer) | ___/___/_____ | ❑ Copy Attached |

**Hepatitis B Vaccination** *--3 doses of vaccine 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/rr6103.pdf for more information.*

*Documentation of Chronic Active Hepatitis B is for rotation assignments and counseling purposes only.*

| | **Date** | | |
|---|---|---|---|
| **Primary Hepatitis B Series** | Hepatitis B Vaccine Dose #1 | ___/___/_____ | |
| | Hepatitis B Vaccine Dose #2 | ___/___/_____ | |
| | Hepatitis B Vaccine Dose #3 | ___/___/_____ | |
| | **QUANTITATIVE** Hep B Surface Antibody | ___/___/_____ | **Result** _____ mIU/ml ❑ Copy Attached |
| **Secondary Hepatitis B Series** (If no response to primary series) | Hepatitis B Vaccine Dose #4 | ___/___/_____ | |
| | Hepatitis B Vaccine Dose #5 | ___/___/_____ | |
| | Hepatitis B Vaccine Dose #6 | ___/___/_____ | |
| | **QUANTITATIVE** Hep B Surface Antibody | ___/___/_____ | **Result** _____ mIU/ml ❑ Copy Attached |
| **Hepatitis B Vaccine Non-responder** (If Hepatitis B Surface Antibody Negative after Primary and Secondary Series) | Hepatitis B Surface Antigen (if 2nd titer negative) | ___/___/_____ | ❑ Copy Attached |
| | Hepatitis B Core Antibody (if 2nd titer negative ) | ___/___/_____ | ❑ Copy Attached |
| **Chronic Active Hepatitis B** | Hepatitis B Surface Antigen | ___/___/_____ | ❑ Copy Attached |
| | Hepatitis B Viral Load | ___/___/_____ | ❑ 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)* | ___/___/_____ | |

# AAMC Standardized Immunization Form

**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)≥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.***

## Tuberculin Screening History

**Please complete one TB section only**

| Section A | | Date Placed | Date Read | Reading | 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 |
| | | | **Date** | **Result** | |
| Last two skin test or IGRAs required<br>Use additional rows as needed | **IGRA Blood Test** (Interferon gamma releasing assay) | | ___/___/____ | ❑ Negative ❑ Indeterminate | ❑ Copy Attached |
| | **IGRA Blood Test** (Interferon gamma releasing assay) | | ___/___/____ | ❑ Negative ❑ Indeterminate | ❑ Copy Attached |
| | **IGRA Blood Test** (Interferon gamma releasing assay) | | ___/___/____ | ❑ Negative ❑ Indeterminate | ❑ Copy Attached |

| Section B | | Date Placed | Date Read | Reading | Interpretation |
|---|---|---|---|---|---|
| **History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test** | Positive TST | ___/___/____ | ___/___/___ | _____ mm | |
| | | | **Date** | **Result** | |
| | Positive IGRA Blood Test | | ___/___/____ | _____ IU | ❑ Copy Attached |
| | Chest X-ray | | ___/___/____ | | ❑ Copy Attached |
| | Prophylactic Medications for latent TB taken? | | | | ❑ Yes ❑ No |
| | Total Duration of prophylaxis? | | | | _____ Months |
| | Date of Last Annual TB Symptom Questionnaire (if applicable) | | | ___/___/____ | ❑ Copy Attached |

| Section C | | Date | |
|---|---|---|---|
| **History of Active Tuberculosis** | Date of Diagnosis | ___/___/___ | |
| | Date of Treatment Completed | ___/___/____ | ❑ Copy Attached |
| | Date of Last Annual TB Symptom Questionnaire (if applicable) | ___/___/____ | ❑ Copy Attached |
| | Date of Last Chest X-ray | ___/___/____ | ❑ Copy Attached |

**Varicella (Chicken Pox)** *-2 doses of vaccine or positive serology*

| | Date | |
|---|---|---|
| Varicella Vaccine #1 | ___/___/_____ | |
| Varicella Vaccine #2 | ___/___/_____ | |
| Serologic Immunity (IgG, antibodies, titer) | ___/___/_____ | ❑ Copy Attached |

# AAMC Standardized Immunization Form

**Name:** _____ **Date of Birth:** _____
(Last, First, Middle Initial) (mm/dd/yyyy)

| **Influenza Vaccine** *--1 dose annually each fall* | | | |
|---|---|---|---|
| | Flu Vaccine | ___/___/____ | ❑ Copy Attached |
| | Flu Vaccine | ___/___/____ | ❑ Copy Attached |

**Additional Information:**

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

| | | |
|---|---|---|
| **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. Updated CDC Recommendations for the Management of Hepatitis B Virus–Infected Health-Care Providers and Students, MMWR Vol 61(RR03):1-12.


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