



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:		

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. <i>Note: a 3rd 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		
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:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Serologic Immunity (IgG antibody 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:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml
Rubella -1 dose of vaccine or positive serology	Rubella Vaccine		Serology Results	
			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		Serology Results	
	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				
		Date		
	Flu Vaccine			



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Hepatitis B Vaccination --3 doses of <i>Engerix-B, Recombivax</i> or <i>Twinrix</i> or 2 doses of <i>Heplisav-B</i> followed by a QUANTITATIVE 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: 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 <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>)	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 <u>Only If no response to primary series</u> <small>Heplisav-B only requires two doses of vaccine followed by antibody testing</small>		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 <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	
Chronic Active Hepatitis B	Hepatitis B Surface Antigen		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Hepatitis B Viral Load		_____ copies/ml	
Additional Vaccines				
<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>				
Vaccination	Date			
Meningococcal Vaccine ACWY				
Additional Comments				



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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) ≥ 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	No history of prior TB Disease or LTBI <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	
			Date	Result		
		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>		
		Section B	Date Placed	Date Read	Result	
	History of LTBI, Positive TB Skin Test, or Positive TB IGRA Blood Test <small>(IGRAs include QuantiFERON TB Gold Test, QuantiFERON TB Gold in-tube test, or T-spot TB Test)</small>	Positive TST		_____ mm		
			Date	Result		
		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 latent TB?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		If treated for latent TB, list medications taken:				
		Total Duration of treatment latent TB?		_____ Months		
Date of Last Annual TB Symptom Questionnaire						
	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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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. 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>.