SCHOOL OF MEDICINE and SCHOOL OF PHARMACY UC SAN DIEGO
IMMUNIZATION REQUIREMENTS

Student ID:	Date of Birth: (MM/DD/YYYY)	Name: First Last

STUDENT AUTHORIZATION TO RELEASE INFORMATION
I authorize UCSD Student Health Services to share information on this form to UCSD School of Medicine or School of Pharmacy Student Affairs for the purpose of clinical placement requirements.

STUDENT SIGNATURE: _____ DATE:_____CELL PHONE NUMBER:_____

Required Immunizations	Required Data PLEASE UPLOAD ALL LABORATORY RESULTS
Tdap (tetanus, diphtheria, pertussis) Td boosters are required every 10 years	**One adult Tdap (after the age of 10). If last Tdap is more than 10 years old, provide last date of Td and Tdap (required)** Tdap Dose date: _____/____/_____ Td Dose date: _____/____/_____
Measles (Rubeola) **Mumps** **Rubella** 2 doses of MMR vaccine **OR** 2 doses of Measles 2 doses of Mumps and 1 dose of Rubella **OR** Serologic proof of immunity for Measles, Mumps and/or Rubella If vaccination is required, first dose must be completed prior to the first day of classes	**MMR Immunizations** Dose 1 date: _____/_____/_____ Dose #1 must be on or after first birthday Dose 2 date: _____/_____/_____ Dose 3 date: _____/_____/_____ (if titer negative) Dose 4 date: _____/_____/_____ (if titer negative) **OR** **Measles – 2 doses of vaccine OR positive serology** **Positive Measles IgG Antibody titer** Titer date: _____/_____/_____ **(a positive titer meets requirement)** **Measles Vaccine Doses x 2** Dose 1 date: _____/_____/_____ Dose 2 date: _____/_____/_____ **Positive Mumps IgG Antibody titer** Titer date _____/_____/_____ **(a positive titer meets requirement)** **Mumps Vaccine Doses x 2** Dose 1 date: _____/_____/_____ Dose 2 date: _____/_____/_____ **Positive Rubella IgG Antibody titer** Titer date _____/_____/_____ **(a positive titer meets requirement)** **Rubella Vaccine Doses x 2** Dose 1 date: _____/_____/_____ Dose 2 date: _____/_____/_____ If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer 4-6 weeks post vaccination. If titer is still negative, receive a second dose of vaccine and repeat titer 4-6 weeks later. Vaccine doses must be at least 28 days apart.

Varicella (Chicken Pox) 2 doses of vaccine **OR** Positive serology	**Positive Varicella IgG Antibody titer (required)** Titer date _____/_____/_____ **(only a positive titer meets requirement)** **OR** **Varicella Immunizations** Dose 1 date: _____/_____/_____ Dose #1 must be on or after the first birthday Dose 2 date: _____/_____/_____ Please check titer first before receiving vaccine If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer 4-6 weeks post vaccination. If titer is still negative, receive second dose of vaccine and repeat titer 4-6 weeks later. Vaccine doses must be at least 28 days apart.
Hepatitis B Two (2) or three (3) doses of vaccine followed by a Quantitative Hep B Surface Antibody (titer) preferably drawn 4-8 weeks after 3rd dose. If negative, complete a second Hep B series followed by a repeat titer. If Hep B Surface Antibody is negative after secondary series, additional testing including Hep B Surface Antigen should be performed. Please see http://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf for more information.	**Hepatitis B Immunizations (required)** Dose 1 date: _____/_____/_____ Dose 2 date: _____/_____/_____ Heplisav B is a 2 dose series Dose 3 date: _____/_____/_____ **Positive Hepatitis B Surface Antibody titer (required) QUANTITATIVE** Titer date: _____/_____/_____**(only a positive titer meets requirement)** **If Hepatitis B Surface Antibody is negative after a full a full primary series, repeat Hepatitis B series** Dose 4 date: _____/_____/_____ Dose 5 date: _____/_____/_____ Dose 6 date: _____/_____/_____ **Positive Hepatitis B Surface Antibody titer (required) QUANTITATIVE** Titer date: _____/_____/_____ **(only a positive titer meets requirement)**
Required if a history of Hep B infection **OR** **Negative Hep B surface antibody** after 2 primary series of Hep B vaccine **OR** **Chronic active Hep B**	**Hepatitis B Core Antibody titer** Titer date: _____/_____/_____ **Hepatitis B Surface Antigen titer** Titer date: _____/_____/_____
Meningococcal Conjugate (MCV4) 1 dose on or after age 16 for all students up to the age of **22 years or younger**	Dose date: _____/_____/_____

I ATTEST THAT ALL DATES AND IMMUNIZATIONS LISTED ON THIS FORM ARE CORRECT AND ACCURATE

Providers Signature: _____ Practice Stamp:

Provider's Name: _____ Date: _____
(Physician/PA/NP/RN)

INSTRUCTIONS

1. **Gather all relevant vaccine history and TB testing results, receive vaccines and/or titers and have your health provider complete this form and sign it.**

2. **Enter this information into the Student Health Services electronic health record MyStudentChart.ucsd.edu/shs/**

3. **Upload this form and ALL associated laboratory/radiology records into your health record: MyStudentChart.ucsd.edu/shs/**

4. **Identify your documents as School of Medicine or School of Pharmacy health requirements**

5. **If you have questions, use the "Ask-A-Nurse" function in your electronic health record.**

6. **Check your UCSD email for alerts from Student Health Services.**