



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:	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 <i>-2 doses of MMR vaccine</i>	MMR Dose #1	_/_/____	
	MMR Dose #2	_/_/____	
Option 2	Vaccine or Test	Date	
Measles <i>-2 doses of vaccine or positive serology</i>	Measles Vaccine Dose #1	_/_/____	
	Measles Vaccine Dose #2	_/_/____	
	Serologic Immunity (IgG, antibodies, titer)	_/_/____	<input type="checkbox"/> Copy Attached
Mumps <i>-2 doses of vaccine or positive serology</i>	Mumps Vaccine Dose #1	_/_/____	
	Mumps Vaccine Dose #2	_/_/____	
	Serologic Immunity (IgG, antibodies, titer)	_/_/____	<input type="checkbox"/> Copy Attached
Rubella <i>-1 dose of vaccine or positive serology</i>	Rubella Vaccine	_/_/____	
	Serologic Immunity (IgG, antibodies, titer)	_/_/____	<input type="checkbox"/> 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/r6103.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
Secondary Hepatitis B Series <small>(If no response to primary series)</small>	Hepatitis B Vaccine Dose #4	_/_/____	
	Hepatitis B Vaccine Dose #5	_/_/____	
	Hepatitis B Vaccine Dose #6	_/_/____	
	QUANTITATIVE Hep B Surface Antibody	_/_/____	Result _____ mIU/ml
Hepatitis B Vaccine Non-responder <small>(If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)</small>	Hepatitis B Surface Antigen (if 2 nd titer negative)	_/_/____	<input type="checkbox"/> Copy Attached
	Hepatitis B Core Antibody (if 2 nd titer negative)	_/_/____	<input type="checkbox"/> Copy Attached
Chronic Active Hepatitis B	Hepatitis B Surface Antigen	_/_/____	<input type="checkbox"/> Copy Attached
	Hepatitis B Viral Load	_/_/____	<input type="checkbox"/> 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)	_/_/____



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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) ≥ 10 mm 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	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	
		TST #2	___/___/___	___/___/___	___ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	
		TST #3	___/___/___	___/___/___	___ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	
	Last two skin test or IGRAs required Use additional rows as needed		IGRA Blood Test <small>(Interferon gamma releasing assay)</small>	___/___/___	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> Copy Attached	
			IGRA Blood Test <small>(Interferon gamma releasing assay)</small>	___/___/___	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> Copy Attached	
			IGRA Blood Test <small>(Interferon gamma releasing assay)</small>	___/___/___	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> 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	<input type="checkbox"/> Copy Attached	
		Chest X-ray		___/___/___		<input type="checkbox"/> Copy Attached	
		Prophylactic Medications for latent TB taken?					<input type="checkbox"/> Yes <input type="checkbox"/> No
		Total Duration of prophylaxis?					___ Months
	Section C			Date			
History of Active Tuberculosis	Date of Diagnosis			___/___/___			
	Date of Treatment Completed			___/___/___	<input type="checkbox"/> Copy Attached		
	Date of Last Annual TB Symptom Questionnaire (if applicable)			___/___/___	<input type="checkbox"/> Copy Attached		
	Date of Last Chest X-ray			___/___/___	<input type="checkbox"/> Copy Attached		

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

	Date	
Varicella Vaccine #1	___/___/___	
Varicella Vaccine #2	___/___/___	
Serologic Immunity (IgG, antibodies, titer)	___/___/___	<input type="checkbox"/> Copy Attached



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Influenza Vaccine -- 1 dose annually each fall			
	Flu Vaccine	___/___/___	<input type="checkbox"/> Copy Attached
	Flu Vaccine	___/___/___	<input type="checkbox"/> 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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List of Participating Institutions

Albert Einstein College of Medicine
Augusta University
Boston University School of Medicine
Brody School of Medicine
Case Western Reserve University School of Medicine
Central Michigan University College of Medicine
Drexel University College of Medicine
East Tennessee State University-Quillen College of Medicine
Georgetown University School of Medicine
International American University College of Medicine
Johns Hopkins University School of Medicine
Kaiser Permanente Medical Center
Kaweah Delta Health Care District
Keck School of Medicine of USC
Louisiana State University Health Sciences Center
Maimonides Medical Center
Marshall University Joan C. Edwards School of Medicine
Medical College of Wisconsin
MetroHealth Medical Center
Michigan State University College of Human Medicine
New York Medical College, Health Services
Northeast Ohio Medical University
Rutgers New Jersey Medical School
Saint Louis University School of Medicine
Stony Brook University School of Medicine
SUNY Downstate Medical Center
Texas Tech University Health Sciences Center
United Health Services Hospital-Wilson Medical Center
University of Arizona College of Medicine—Phoenix
University of Arizona College of Medicine—Tucson
University of California Davis School of Medicine
University of Cincinnati College of Medicine
University of Illinois College of Medicine at Peoria
University of Louisville School of Medicine
University of Maryland School of Medicine
University of North Carolina School of Medicine
University of South Florida Morsani College of Medicine
University of Tennessee Health Science Center
University of Texas Southwestern Medical Center
University of Vermont College of Medicine
University of Washington School of Medicine
Washington St. Louis School of Medicine
Wayne State University School of Medicine
Wright State University Boonshoft School of Medicine
Yale School of Medicine