

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
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:	☐ Positive ☐ 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:	☐ Positive ☐ 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:	☐ Positive ☐ Negative	
	Serologic Immunity (IgG antibody 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 dates 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	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml	
Influenza Vaccine - 1 dose annually each fall					
Date of last dose		Date			☐
	Flu Vaccine				
COVID-19 Vaccine - primary series of two (2) doses and booster dose		Date	Company or Trade Name		
	COVID-19 Vaccine #1				☐
	COVID-19 Vaccine #2				
	COVID-19 Booster Bivalent Vaccine				

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Hepatitis B Vaccination - 3 doses of <i>Engerix-B</i> , <i>PreHevbrio</i> , <i>Recombivax</i> or <i>Twinrix</i> vaccines or 2 doses of <i>Heplisav-B</i> vaccine followed by a QUANTITATIVE Hepatitis B Surface Antibody test drawn 4-8 weeks after last vaccine dose. A test titer ≥ 10 mIU/mL is positive for immunity. If the test result is negative, repeat another Hepatitis B vaccine series followed by a repeat test titer. If the Hepatitis B Surface Antibody test is negative after the repeat vaccine series, a "non-responder" status is assigned. See: http://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf for more information.				Copy Attached	
Primary Hepatitis B Series Heplisav-B only requires two doses of vaccine followed by antibody testing	3-dose vaccines (<i>Energix-B</i> , <i>PreHevbrio</i> , <i>Recombivax</i> , <i>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 Test		_____ mIU/ml		
Repeat Hepatitis B Series <u>Only If no response to primary series</u> 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 Test		_____ mIU/ml		
Hepatitis B Vaccine Non-responder	If the Hepatitis B Surface Antibody test is negative (titer less than 10 mIU/mL) after a primary and repeat vaccine series, vaccine non-responders should be counseled and evaluated appropriately. Certain institutions may request signing an "acknowledgement of non-responder status" document before clinical placements.				
Additional Documentation					
<u>Some institutions</u> 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.					
Vaccination, Test or Examination		Date	Result or Interpretation		
Physical Exam (if required)					

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TUBERCULOSIS (TB) SCREENING – All U.S. healthcare personnel are screened pre-placement for TB. Results of the last (2) TB Skin Tests (TSTs) or (1) IGRA blood test are required regardless of prior BCG status. The 2-step TST protocol must have been placed within the past 12 months prior to clinical duties, and must have been performed in the U.S. The second TST must be placed at least 1 week after the first TST read date. If you have a history of a positive TST (PPD) ≥ 10 mm or a positive IGRA blood test, please supply information regarding any evaluation and/or treatment below. You only need to complete ONE section, A or B.

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
	History of Negative TB Skin Test or Blood Test <u>T-spots or QuantiFERON TB Gold blood tests for tuberculosis</u> Use additional rows as needed	TST #1			_____ mm	☐ Pos ☐ Neg ☐ Equiv
		TST #2			_____ mm	☐ Pos ☐ Neg ☐ Equiv
				Date	Result	
		QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)			☐ Positive ☐ Negative ☐ Indeterminate	
		QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)			☐ Positive ☐ Negative ☐ Indeterminate	
	Section B		Date Placed	Date Read	Result	
	History of 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*			*Provide documentation or result	
		Treated for latent TB infection (LTBI)?			☐ Yes ☐ No	
		Date of Last Annual TB Symptom Questionnaire				



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Additional Information

MUST BE SIGNED BY A LICENSED HEALTHCARE PROFESSIONAL OR DESIGNEE:

Healthcare Professional 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
5. Sosa LE, Nijie GL, Lobato MN, et.al. Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from National Tuberculosis Controllers Association and CDC, 2019. MMWR2019;68:439-443. https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s_cid=mm6819a3_w