







## Professional Student Immunization Requirements

<b>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.</b>					<b>Copy Attached</b>
<b>Option 1</b>	<b>Vaccine</b>	<b>Date</b>			
<b>MMR</b> - 2 doses of MMR vaccine	MMR Dose #1	__ / __ / ____			<input type="checkbox"/>
	MMR Dose #2	__ / __ / ____			
<b>Option 2</b>	<b>Vaccine or Test</b>	<b>Date</b>			
<b>Measles</b> - 2 doses of vaccine	Measles vaccine Dose #1	__ / __ / ____			<input type="checkbox"/>
	Measles vaccine Dose #2	__ / __ / ____			
<b>OR</b> positive Measles serology	Serologic Immunity (IgG, antibodies, titer)	__ / __ / ____	Qualitative Titer Results: Quantitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative _____ IU/ml	
<b>Mumps</b> - 2 doses of vaccine	Mumps vaccine Dose #1	__ / __ / ____			<input type="checkbox"/>
	Mumps vaccine Dose #2	__ / __ / ____			
<b>OR</b> positive Mumps serology	Serologic Immunity (IgG, antibodies, titer)	__ / __ / ____	Qualitative Titer Results: Quantitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative _____ IU/ml	
<b>Rubella</b> - 1 dose of vaccine	Rubella vaccine	__ / __ / ____			<input type="checkbox"/>
<b>OR</b> positive Rubella serology	Serologic Immunity (IgG, antibodies, titer)	__ / __ / ____	Qualitative Titer Results: Quantitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative _____ IU/ml	
<b>Tetanus-diphtheria-pertussis – One (1) dose of adult Tdap. If last Tdap was more than 10 years old, provide date of last Td and Tdap.</b>					
	Tdap Vaccine (Adacel, Boostrix, etc.)	__ / __ / ____			<input type="checkbox"/>
	Td Vaccine (if more than 10 years since last Tdap)	__ / __ / ____			
<b>Varicella (Chicken Pox) – 2 doses of vaccine or positive serology</b>					
	Varicella Vaccine #1	__ / __ / ____			<input type="checkbox"/>
	Varicella Vaccine #2	__ / __ / ____			
<b>OR</b> positive Varicella serology	Serologic Immunity (IgG, antibodies, titer)		Qualitative Titer Results: Quantitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative _____ IU/ml	

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<p><b>Hepatitis B Vaccination</b> – 3 doses of Engergix-B, Recombivax or Twinrix or 2 doses of Heplisav-B followed by a QUANTITATIVE Hepatitis B Surface Antibody (titer) preferably drawn 4-8 weeks after 3rd dose. If negative, give a 4th dose and repeat a titer in 4-8 weeks. If negative complete the remainder of the second series followed by another titer drawn 4-8 weeks after the last dose of the second series. If Hepatitis B Surface Antibody is still negative after a secondary series, additional testing including Hepatitis B Surface Antigen should be performed. Documentation of Chronic Active Hepatitis B is for rotation assignments and counseling purposes only.</p>				<p><b>Copy Attached</b></p>
<p><b>Primary Hepatitis B Series</b> Heplisav-B only requires 2 two doses of vaccine followed by antibody testing</p>	<p>3-dose vaccines (Engergix B, Recombivax or Twinrix)</p>	<p><b>3 Dose Series</b></p>	<p><b>2 Dose Series</b></p>	
	<p>2 dose vaccines (Heplisav-B)</p>			
	<p>Hepatitis B Vaccine Dose #1</p>	<p>/ /</p>	<p>/ /</p>	
	<p>Hepatitis B Vaccine Dose #2</p>	<p>/ /</p>	<p>/ /</p>	
	<p>Hepatitis B Vaccine Dose #3</p>	<p>/ /</p>		
<p>Quantitative Hep B Surface Antibody</p>	<p>_ / _ / _</p>	<p>___ IU/ml</p>		
<p><b>Secondary Hepatitis B Series</b> Only if no response to primary series Heplisav-B only requires 2 two doses of vaccine followed by antibody testing</p>		<p><b>3 Dose Series</b></p>	<p><b>2 Dose Series</b></p>	
	<p>Hepatitis B Vaccine Dose #4</p>	<p>/ /</p>	<p>/ /</p>	
	<p>Hepatitis B Vaccine Dose #5</p>	<p>/ /</p>	<p>/ /</p>	
	<p>Hepatitis B Vaccine Dose #6</p>	<p>/ /</p>		
	<p>Quantitative Hep B Surface Antibody</p>	<p>_ / _ / _</p>	<p>___ IU/ml</p>	
<p><b>Hepatitis B Vaccine Non-responder</b> (If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)</p>	<p>Hepatitis B Surface Antigen</p>	<p>/ /</p>	<p><input type="checkbox"/> Positive <input type="checkbox"/> Negative</p>	
	<p>Hepatitis B Core Antibody</p>	<p>_ / _ / _</p>	<p><input type="checkbox"/> Positive <input type="checkbox"/> Negative</p>	
<p><b>Chronic Active Hepatitis B</b></p>	<p>Hepatitis B Surface Antigen</p>	<p>/ /</p>	<p><input type="checkbox"/> Positive <input type="checkbox"/> Negative</p>	
	<p>Hepatitis B Viral Load</p>	<p>/ /</p>	<p>___ copies/ml</p>	

## Professional Student Immunization Requirements

**TUBERCULOSIS SCREENING – HISTORY DEPENDENT. COMPLETE ONE SECTION ONLY.**

**Section A: (History of Negative TB Screening)** At least one IGRA (QuantIFERON or T-SPOT) blood test performed within three months of first date on campus, or at least two Tuberculin skin tests, one of which must be completed within three months of first date on campus and the second within twelve months of first date on campus.

**Section B: (History of Positive TB Screening)** Documentation of positive testing, treatment if any, and a chest x-ray performed within three months of first date on campus.

**Section C: (History of Active TB Disease)** All fields completed. Chest x-ray must be performed within three months of first date on campus.

### Tuberculosis Screening History

Please complete only one TB section based on your history	<b>Section A</b>		<b>Date Placed</b>	<b>Date Read</b>	<b>Result</b>	<b>Interpretation</b>	<b>Copy Attached</b>
	<b>Negative Skin or Blood Test History</b>  Last two skin test or IGRAs required  T-Spot or QuantiFERON TB Gold blood tests for tuberculosis  Use additional rows as needed	Test #1	/ /	/ /	mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	<input type="checkbox"/>
		Test #2	/ /	/ /	mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	<input type="checkbox"/>
		Test #3	/ /	/ /	mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	<input type="checkbox"/>
		Test #4	/ /	/ /	mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	<input type="checkbox"/>
				<b>Date</b>	<b>Result</b>		
		QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>	_ / _ / _	_ / _ / _	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/>	
		QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>	_ / _ / _	_ / _ / _	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/>	
		QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>	_ / _ / _	_ / _ / _	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/>	
	QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>	_ / _ / _	_ / _ / _	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/>		
	<b>Section B</b>		<b>Date Placed</b>	<b>Date Read</b>	<b>Result</b>		
	<b>History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test</b>  IGRAs include T-Spots or QuantiFERON TB Gold blood tests for tuberculosis	Positive Test	_ / _ / _	_ / _ / _	_ mm	<input type="checkbox"/>	
				<b>Date</b>	<b>Result</b>		
		QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>	_ / _ / _	_ / _ / _	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/>	
		Chest X-ray	/ /			<input type="checkbox"/>	
		Treated for latent TB?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
		If treated for latent TB, list medications taken:					
		Total Duration of treatment latent TB?			_ Months		
		Date of Last Annual TB Symptom Questionnaire			_ / _ / _		
	<b>Section C</b>				<b>Date</b>		
	<b>History of Active Tuberculosis</b>	Date of Diagnosis			_ / _ / _	<input type="checkbox"/>	
		Date of Treatment Completed			_ / _ / _		
		Date of Last Annual TB Symptom Questionnaire			_ / _ / _		
		Date of Last Chest X-ray			_ / _ / _		

## Professional Student Immunization Requirements

<p><b>COVID-19 Vaccination</b> – one (1) dose of Johnson &amp; Johnson COVID-19 vaccine plus a booster two months after first dose or, two (2) doses of Moderna COVID-19 vaccine plus a booster five months after second dose or, two (2) doses of Pfizer COVID-19 vaccine plus a booster five months after second dose.</p> <p>WHO-EUL vaccines may also meet the requirements. Please see the drop-down list in <a href="https://myhealthrecord.ucsf.edu">https://myhealthrecord.ucsf.edu</a>.</p>			<b>Copy Attached</b>
Option 1	Vaccine	Date	
1 dose of Johnson & Johnson vaccine plus booster	Dose #1	__ / __ / ____	<input type="checkbox"/>
	Dose #2	__ / __ / ____	
Option 2	Vaccine	Date	
2 doses of Moderna vaccine plus booster	Dose #1	__ / __ / ____	<input type="checkbox"/>
	Dose #2	__ / __ / ____	
	Dose #3	__ / __ / ____	
Option 3	Vaccine	Date	
2 doses of Pfizer vaccine plus booster	Dose #1	__ / __ / ____	<input type="checkbox"/>
	Dose #2	__ / __ / ____	
	Dose #3	__ / __ / ____	