













Professional Student Immunization Requirements

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	Measles vaccine Dose #1	__ / __ / ____			
	Measles vaccine Dose #2	__ / __ / ____			
OR positive Measles serology	Serologic Immunity (IgG, antibodies, titer)	__ / __ / ____	Qualitative Titer Results: Quantitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative _____ IU/ml	
Mumps - 2 doses of vaccine	Mumps vaccine Dose #1	__ / __ / ____			
	Mumps vaccine Dose #2	__ / __ / ____			
OR positive Mumps serology	Serologic Immunity (IgG, antibodies, titer)	__ / __ / ____	Qualitative Titer Results: Quantitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative _____ IU/ml	
Rubella - 1 dose of vaccine	Rubella vaccine	__ / __ / ____			
OR positive Rubella serology	Serologic Immunity (IgG, antibodies, titer)	__ / __ / ____	Qualitative Titer Results: Quantitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative _____ IU/ml	
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.					
	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	__ / __ / ____			
	Varicella Vaccine #2	__ / __ / ____			
OR 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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Hepatitis B Vaccination – 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.				Copy Attached
Primary Hepatitis B Series Heplisav-B only requires 2 two doses of vaccine followed by antibody testing	3-dose vaccines (Engergix B, Recombivax or Twinrix)	3 Dose Series	2 Dose Series	
	2 dose vaccines (Heplisav-B)			
	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> Heplisav-B only requires 2 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	_ / _ / _	_ IU/ml	
Hepatitis B Vaccine Non-responder (If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)	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	

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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	Section A		Date Placed	Date Read	Result	Interpretation	Copy Attached
	Negative Skin or Blood Test History 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"/>
				Date	Result		
		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"/>		
	Section B		Date Placed	Date Read	Result		
	History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test IGRAs include T-Spots or QuantiFERON TB Gold blood tests for tuberculosis	Positive Test	_ / _ / _	_ / _ / _	_ mm	<input type="checkbox"/>	
				Date	Result		
		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			_ / _ / _		
	Section C			Date			
	History of Active Tuberculosis	Date of Diagnosis			_ / _ / _	<input type="checkbox"/>	
		Date of Treatment Completed			_ / _ / _		
		Date of Last Annual TB Symptom Questionnaire			_ / _ / _		
		Date of Last Chest X-ray			_ / _ / _		

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<p>COVID-19 Vaccination – one (1) dose of Johnson & 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. Also needed is bivalent booster or declination of COVID-19 booster.</p> <p>Upload your COVID-19 records via the Occupational Health Services Portal. You must be logged into a UCSF network or sign on to Pulse Secure VPN. Find out how to access VPN here: https://it.ucsf.edu/service/vpn. The OHS portal is the central repository for the entire UCSF community COVID-19 vaccination data and used for compliance and reporting purposes.</p> <p>WHO-EUL vaccines may also meet the requirements. Please see the drop-down list in https://myhealthrecord.ucsf.edu.</p>			Copy Attached
Option 1	Vaccine	Date	
1 dose of Johnson & Johnson vaccine plus booster	Dose #1	__ / __ / ____	
	Dose #2	__ / __ / ____	
	Bivalent booster or declination of booster	__ / __ / ____	
Option 2	Vaccine	Date	
2 doses of Moderna vaccine plus booster	Dose #1	__ / __ / ____	
	Dose #2	__ / __ / ____	
	Dose #3	__ / __ / ____	
	Bivalent booster or declination of booster	__ / __ / ____	
Option 3	Vaccine	Date	
2 doses of Pfizer vaccine plus booster	Dose #1	__ / __ / ____	
	Dose #2	__ / __ / ____	
	Dose #3	__ / __ / ____	
	Bivalent booster or declination of booster	__ / __ / ____	