UCSF Student Health & Counseling
Student Academic Affairs

# 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: | ☐ Positive ☐ 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: | ☐ Positive ☐ 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: | ☐ Positive ☐ 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: | ☐ Positive ☐ 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)<br>2 dose vaccines (Heplisav-B) | **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 | __ / __ / ____ | ____ 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 | __ / __ / ____ | ☐ Positive ☐ Negative | |
| | Hepatitis B Core Antibody | __ / __ / ____ | ☐ Positive ☐ Negative | |
| **Chronic Active Hepatitis B** | Hepatitis B Surface Antigen | __ / __ / ____ | ☐ Positive ☐ 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** | Test #1 | __/__/____ | __/__/____ | ___mm | ☐ Pos ☐ Neg ☐ Equiv | |
| | Test #2 | __/__/____ | __/__/____ | ___mm | ☐ Pos ☐ Neg ☐ Equiv | |
| | Test #3 | __/__/____ | __/__/____ | ___mm | ☐ Pos ☐ Neg ☐ Equiv | |
| | Test #4 | __/__/____ | __/__/____ | ___mm | ☐ Pos ☐ Neg ☐ Equiv | |
| Last two skin test or IGRAs required | | | **Date** | **Result** | | |
| T-Spot or QuantiFERON TB Gold blood tests for tuberculosis Use additional rows as needed | **QuantiFERON TB Gold or T-Spot** (Interferon Gamma Releasing Assay) | | __/__/____ | ☐ Negative ☐ Indeterminate | | |
| | **QuantiFERON TB Gold or T-Spot** (Interferon Gamma Releasing Assay) | | __/__/____ | ☐ Negative ☐ Indeterminate | | |
| | **QuantiFERON TB Gold or T-Spot** (Interferon Gamma Releasing Assay) | | __/__/____ | ☐ Negative ☐ Indeterminate | | |
| | **QuantiFERON TB Gold or T-Spot** (Interferon Gamma Releasing Assay) | | __/__/____ | ☐ Negative ☐ Indeterminate | | |
| **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 | | |
| | | | **Date** | **Result** | | |
| | **QuantiFERON TB Gold or T-Spot** (Interferon Gamma Releasing Assay) | | __/__/____ | ☐ Positive ☐ Negative ☐ Indeterminate | | |
| | Chest X-ray | | __/__/____ | | | |
| | Treated for latent TB? | | | ☐ Yes ☐ No | | |
| | 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 | | | __/__/____ | | |
| | Date of Treatment Completed | | | __/__/____ | | |
| | Date of Last Annual TB Symptom Questionnaire | | | __/__/____ | | |
| | Date of Last Chest X-ray | | | __/__/____ | | |