UCSF Student Health & Counseling
Student Academic Affairs

Immunization Form 2015-16

Please complete and return to Student Health and Counseling Services

First Name _____ Middle Name _____ Last Name _____

Date of Birth _____ Phone # _____ Email address _____ School/Program _____ Gender _____

Immunization/TB Screening Categories	Required Data Submitted via the Online Immunization Portal (SAA Student Portal)
Measles (Rubeola) **NOTE:** A **PPD skin test** must be placed the SAME day as a **live virus vaccine** OR at least 30 days after the administration of a live virus vaccine to be considered valid. Mail in copy of titer result lab report.	**Positive Measles IgG Antibody titer (required)** Titer Date _____/_____/_____ (positive titer only meets requirement) **Measles or MMR Immunizations** Dose 1 date: _____/_____/_____ □ Measles or □ MMR (select one) Dose 2 date: _____/_____/_____ □ Measles or □ MMR (select one) • Strongly Recommended: dates of a previous dose of vaccine (measles or MMR) • If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer. If titer is still negative, contact Student Health. • Vaccine doses must be at least 28 days apart.
Mumps **NOTE:** A **PPD skin test** must be placed the SAME day as a **live virus vaccine** OR at least 30 days after the administration of a live virus vaccine to be considered valid. Mail in copy of titer result lab report.	**Positive Mumps IgG Antibody titer (required)** Titer Date _____/_____/_____ (positive titer only meets requirement) **Mumps or MMR Immunizations** Dose 1 date: _____/_____/_____ □ Mumps or □ MMR (select one) Dose 2 date: _____/_____/_____ □ Mumps or □ MMR (select one) • Strongly Recommended: dates of a previous dose of vaccine (mumps or MMR) • If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer. If titer is still negative, contact Student Health. • Vaccine doses must be at least 28 days apart.
Rubella **NOTE:** A **PPD skin test** must be placed the SAME day as a **live virus vaccine** OR at least 30 days after the administration of a live virus vaccine to be considered valid. Mail in copy of titer result lab report.	**Positive Rubella IgG Antibody titer (required)** Titer Date _____/_____/_____ (positive titer only meets requirement) **Rubella or MMR Immunizations** Dose 1 date: _____/_____/_____ □ Rubella or □ MMR (select one) • Strongly Recommended: dates of a previous dose of vaccine (rubella or MMR) • If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer. If titer is still negative, contact Student Health.

Student Name: _____

Varicella (chicken pox) **NOTE:** A **PPD skin test** must be placed the SAME day as a **live virus vaccine** OR at least 30 days after the administration of a live virus vaccine to be considered valid. History of disease is not sufficient. Mail in copy of titer result lab report.	**Positive Varicella IgG Antibody titer (required)** Titer Date _____/_____/_____ (positive titer only meets requirement) **Varicella Immunizations** Dose 1 date: _____/_____/_____ Dose 2 date: _____/_____/_____ Please check titer first before receiving vaccine • Strongly Recommended: dates of two previous doses of vaccine (varicella) • If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer. If titer still negative, receive second dose of vaccine and repeat titer. If titer is still negative, contact Student Health. • Vaccine doses must be at least 28 days apart.
Tdap (tetanus, diphtheria, pertussis)	**Tdap vaccine (required)** Dose 1 date: _____/_____/_____ • Vaccine must be Tdap, not Td. • Tdap is required regardless of date of last Td injection.
Hepatitis B Items **A, B, or C** on right will meet requirements. Mail in copy of titer result lab report.	A. **At least 2 of 3 doses** of Hepatitis B vaccine required (**all 3 doses** required if you have time to complete series), provide all three dates if series complete, **AND** **Positive Hepatitis B surface antibody** (required if you have completed the Hep B series) **Hepatitis B Immunizations** Dose 1 date: _____/_____/_____ Dose 2 date: _____/_____/_____ Dose 3 date: _____/_____/_____ **Hepatitis B Surface Antibody titer (required if series above complete)** Titer Date _____/_____/_____ (positive titer only meets requirement) **OR** B. **History of Hep B infection**: **Core antibody & surface antigen titer results** (these titers submitted in instance of prior infection). Only positive titers reflect history of past disease. If these titers are negative you should be immunized and obtain the surface antibody titer. **Hepatitis B Core Antibody titer** Titer Date _____/_____/_____ **Hepatitis B Surface Antigen titer** Titer Date _____/_____/_____ **OR** C. **Received vaccination and titer didn't convert to positive**: If you have completed the Hep B series of 3 immunizations and your titer doesn't convert to reactive/positive, you must obtain and submit the date for a 4th dose of Hep B. Also submit the date of the previous three immunizations and negative/non-reactive titer. If you have already received two full course of Hep B vaccination (6 doses – 2 series of 3 shots) submit the dates of ALL doses of vaccine and negative titer.

Student Name: _____

Hepatitis B (cont'd)

Mail in copy of titer result lab report.

Hepatitis B Immunizations

Dose 1 date: _____/_____/_____

Dose 2 date: _____/_____/_____

Dose 3 date: _____/_____/_____

Dose 4 date: _____/_____/_____

Dose 5 date: _____/_____/_____

Dose 6 date: _____/_____/_____

Hepatitis B Surface Antibody titer (required if series above complete)

Titer Date _____/_____/_____ (☐ positive titer ☐ negative titer)

Notes:
The Hepatitis B vaccination series requires 3 vaccinations given at minimum intervals of 0, 30 and 240 days (0, 1, and 6 months). Greater intervals are permissible. Do not restart a vaccination series; just pick up where you left off.

Following the completion of the series, and at least 4 weeks after the last dose, a Hepatitis B *Surface Antibody* titer must be drawn to confirm immunity.

TB Screening

- Please complete the 'Negative TB Screen' section if you have a history of negative TB screening (skin test, QFT, TSpot)
- Please complete the '*Positive TB* Screen' section if you have a history of positive TB screening (skin test, QFT, TSPot)

Negative TB Screen

(Please submit data for either **A, B, or C**. *Any* of the options will meet the requirement.)

NOTE: A **PPD skin test** must be placed the SAME day as a live virus vaccine OR at least 28 days after the administration of a live virus vaccine to be considered valid. Live virus vaccines include measles, mumps, rubella, and varicella.

A. PPD Skin Test performed by either method below:

Two-step PPD skin testing: Two PPD (tuberculosis skin testing) skin tests administered 7-31 days apart in the three months preceding entry into school, (Note: Do not have a TB skin test placed for 28 days following a live virus vaccine – must be placed same day as the live virus).

Kaiser Permanente patients may have a slightly altered PPD skin test pattern. Kaiser requests that patient have a PPD skin test placed, come back 7 days later for a read and have the second skin test placed on that same day.

or

History of regular skin testing: Documentation of a TB skin test completed within the three months prior to starting school and documentation of an additional skin test completed within one year of the more recent test.

PPD Test 1 Placement_____/_____/____ **Reading**____/_____/____ **reading** _____ **mm**

PPD Test 2 Placement_____/_____/____ **Reading**____/_____/____ **reading** _____ **mm**

OR

B. QuantiFERON testing: Documentation of a negative QuantiFERON Gold test reported within three months of entering school, (positive test, see below)

Test Date _____/_____/_____ **(only a negative test meets requirement)**

OR

C. T-SPOT testing: Documentation of a negative T-SPOT.TB test reported within three months of entering school, (positive test, see below)

Test Date _____/_____/_____ **(only a negative test meets requirement)**

Positive TB Screen

(Please submit data for **D, E, and F**. *All* data must be submitted to meet the requirement.)

D. POSITIVE skin test (reading > 10 mm) or POSITIVE QuantiFERON or POSITIVE T-SPOT:

PPD Read Date_____/_____/____ **reading** _____ **mm**

OR

Student Name: _____

Positive TB Screen (Cont'd)

(Please submit data for **D, E, and F**. All data must be submitted to meet the requirement.)

QuantiFERON testing: Documentation of a positive QuantiFERON Gold test

Test Date _____/_____/_____

OR

T-SPOT testing: Documentation of a positive T-SPOT.TB test

Test Date _____/_____/_____

AND

E. Chest X-ray

- Chest x-ray report: required

  x-ray results: ☐ normal ☐ abnormal

  Date: _____/_____/_____

Note: Date of chest x-ray report must be within 3 months of entering UCSF if INH Therapy has been taken for less than 6 months. If 6 months of INH therapy taken, chest xray report can be from time of positive screen.

AND

F. INH therapy taken:

☐ yes ☐ no

Date started: _____/_____/_____ Date ended: _____/_____/_____

length of treatment _____ months

Question about BCG? Students born outside the U.S. who received BCG vaccine should follow the TB screening requirements as listed above. If you have had slight reactions to a PPD skin test in the past, it is recommended you opt for QuantiFERON or T-Spot testing.

TB Screening Questions **REQUIRED**

Have you ever received BCG?	☐ yes ☐ no **if yes:** Year _____ Country _____
	Country of Birth _____
Have you traveled and/or lived overseas in the past year?	☐ yes ☐ no **if yes:** Countries _____
	Last Return Date _____
Have you worked in a prison or homeless shelter in the past year?	☐ yes ☐ no
Have you entered a TB isolation room in the past year?	☐ yes ☐ no
Have you had exposure to a known case of TB in the past year?	☐ yes ☐ no
In the past six months have you experienced any of the following for greater than three weeks?	
Excessive sweating at night	☐ yes ☐ no
Excessive weight loss	☐ yes ☐ no
Persistent coughing	☐ yes ☐ no
Excessive Fatigue	☐ yes ☐ no
Coughing up blood	☐ yes ☐ no
Hoarseness	☐ yes ☐ no
Persistent fever	☐ yes ☐ no

I attest that all dates and immunizations listed on this form are correct and accurate.

Provider's Signature _____ Date _____
Physician, Nurse Practitioner, Physician's Assistant, or RN

Provider's name printed_____Phone number _____
Physician, Nurse Practitioner, Physician's Assistant, or RN

Clinic Stamp - If the verifying provider's office has clinic stamp, please place here.