USA Standardized Immunization Form

Last Name:		First Name:		Middle Initial:	
DOB:		Street Address:			
College:		City:			
Cell Phone:		State:			
Primary Email:		ZIP Code:			

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; and serologic proof of immunity for Measles, Mumps and/or Rubella.*

	Vaccine	Date			Copy Attached
MMR *-2 doses of MMR vaccine*	MMR Dose #1				
	MMR Dose #2				
	Test	**Date**			
Measles *-2 doses of vaccine and 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 and 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 and positive serology*			**Serology Results**		
	Rubella Vaccine		Qualitative Titer Results:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_______ IU/ml	

Tetanus-diphtheria-pertussis – *1 dose of adult Tdap; if last Tdap is more than 10 years old, provide date of last Td or Tdap booster*

				Copy Attached
	Tdap Vaccine (Adacel, Boostrix, etc)			
	Td Vaccine or Tdap Vaccine booster *(if more than 10 years since last Tdap)*			

Varicella (Chicken Pox) - *2 doses of varicella vaccine and positive serology*

					Copy Attached
	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		Copy Attached
	Flu Vaccine			

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(Last, First, Middle Initial) (mm/dd/yyyy)

Hepatitis B Vaccination *--3 doses of Engerix-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 the last dose. If negative titer (<10 IU/ml) complete a second Hepatitis B series followed by a repeat titer. If Hepatitis B Surface Antibody titer is negative after a secondary series, a non-responder letter may be issued.*				Copy Attached
Primary Hepatitis B Series Heplisav-B only requires two doses of vaccine followed by antibody testing	3-dose vaccines (Engerix-B, Recombivax, Twinrix) or 2-dose vaccine (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 *Only If no response to primary series* 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		_______ 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	

Additional Vaccines

Some states and institutions *may have additional vaccine requirements for students, health sciences personnel, and first responders depending upon assignment, school requirements or state law.*

Vaccination	**Date**	
Additional Comments		

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CDC Recommendations: Preplacement (baseline) TUBERCULOSIS SCREENING AND TESTING of all health care personnel/ trainees consists of a TB symptom evaluation, a TB test (IGRA or TST), and an individual TB risk assessment. You only need to complete ONE section below: A or B or C.

Section A: If you do not have a history of TB disease or LTBI (Latent Tuberculosis Infection), the results of a 2-step TST (Tuberculosis Skin Test), or TB IGRA (Interferon Gamma Release Assay) blood test are required, **regardless** of your prior BCG status. You should also check off the results of your individual baseline TB symptom evaluation and TB risk assessment questionnaire.

Section B: If you have a history of a positive TST (PPD)≥10mm or a positive IGRA, please supply information regarding further medical evaluation and treatment below.

Section C: History of active tuberculosis, diagnosis and treatment.

Tuberculosis Screening History

Please complete only one TB section based on your history

Section A		Date Placed	Date Read	Result	Interpretation	Copy Attached
No history of prior TB Disease or LTBI Dates of the last 2-step TST or TB IGRA blood test are required (IGRAs include QuantiFERON TB Gold Test, QuantiFERON TB Gold in-tube test, or T-spot TB Test)	**TST step #1**			____mm	❑ Pos ❑ Neg ❑ Equiv	
	TST step #2			____mm	❑ Pos ❑ Neg ❑ Equiv	
			Date	**Result**		
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Release Assay)			❑ Negative	❑ Indeterminate	
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Release Assay)			❑ Negative	❑ Indeterminate	
	Individual TB Symptom Assessment			❑ Negative	❑ Positive (Medical follow-up needed)	
	Individual TB Risk Assessment			❑ Negative	❑ Positive (Increased risk TB infection)	

Section B		Date Placed	Date Read	Result	Copy Attached
History of LTBI, Positive TB Skin Test, or Positive TB IGRA Blood Test (IGRAs include QuantiFERON TB Gold Test, QuantiFERON TB Gold in-tube test, or T-spot TB Test)	Positive TST			________ mm	
			Date	**Result**	
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Release 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	Copy Attached
History of Active Tuberculosis	Date of Diagnosis		
	Date of Treatment Completed		
	Date of Last Annual TB Symptom Questionnaire		
	Date of Last Chest X-ray		

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MUST BE COMPLETED BY YOUR HEALTH CARE PROVIDER OR INSTITUTIONAL DESIGNEE:

Authorized Signature:		**Date:**
Printed Name:		Office Use Only
Title:		
Address Line 1:		
Address Line 2:		
City:		
State:		
Zip:		
Phone:	(____) ______-____________ **Ext:** _______	
Fax:	(____) ______-____________	
Email Contact:		