**Immunization Requirements**

A. All students must provide proof of completion of the *Hepatitis B* series of immunizations and serologic testing of immunity to Hepatitis B (titer). If Hepatitis B Titer is negative, repeat booster and re-do titer in 4 to 8 weeks.

B. Students born after 1956 must provide proof of immunization to MMR (Measles, Mumps, and Rubella) or are required to have serologic evidence of immunity to MMR (titer).

C. All students must provide *annual* proof of a PPD Tuberculin skin test. Students who test positive to PPD or have received the BCG vaccine, must provide results of a QFT blood test dated November 1 or later.

D. All students must provide proof of Varicella immunization or serologic evidence of immunity to Varicella (titer) or documented case of chickenpox.

E. All students must provide proof of a Tetanus (Td) booster within the past 10 years, and a one-time adult dose of Pertussis (Tdap).

F. All students will be required to receive Influenza vaccine each "flu season" in accordance with CDC Healthcare Personnel recommendations.

All entering students must submit a 'Record of Required Immunizations' form signed by a Healthcare provider. The form must include a record of all completed vaccinations and required titers or vaccinations that are in progress at the time of submission. Subsequent documentation for missing immunizations should be provided as requirements are met. The completed form should be sent to OMSE/Health Record Administration US Mail, Email to: UMMS.Health.Records@umich.edu or Faxed to: (734) 764-764-9473.

Revised 12/2016
2017 RECORD OF REQUIRED IMMUNIZATIONS
University of Michigan Medical School
1135 Catherine Street, SPC 5726 • Ann Arbor MI 48109-5726 • Fax (734) 764-9473

PART I - TO BE COMPLETED BY THE STUDENT

Name

Last First MI

Date of Birth: ____________________________

Street Address: ____________________________________________________________

City: __________________________ State: ___________ Zip: __________________

Phone: (______)_____________ ___________ ___________ ___________ Today’s Date: ___________

PART II - TO BE COMPLETED AND SIGNED BY A LICENSED HEALTH CARE PROVIDER

A. Hepatitis B Vaccination

1. ..................................................................................................................... Month/Year ___________ // ______

2. ..................................................................................................................... Month/Year ___________ // ______

3. ..................................................................................................................... Month/Year ___________ // ______

4. Antibody Titer: (Required)

   Result…Positive/Immune ___ Negative/Non-Immune ___ Month/Year ___________ // ______

   • If Negative: Booster………………………………………………………... Month/Year _______

   • New Titer:   Result…Positive/Immune ___ Negative/Non-Immune ___ Month/Year ___________ // ______

B. Measles, Mumps, and Rubella

1. 2 Doses of MMR Vaccine…………………………………………………. Month/Year _______//_________

   Or . . .

2. Immune Titer (Required to be positive) …………………………………….. Month/Year ___________ // ______

C. Tuberculosis

1. If PPD Negative dated November 1, 2016 or later …………………….. Month/Year __________________

   (Re-test Annually)

2. If PPD Positive, then QFT (Quantiferon Gold Test) dated November 1, 2016 or later

   QFT…… Positive ___   Negative ___............. Month/Year ___________ // ______

   • If QFT positive – refer for evaluation and treatment

   • If QFT negative – annual symptom review recommended

3. EXCEPTION: Known exposure in past to BCG, then QFT dated

   November 1, 2016 or later. (Re-test Annually) ………………………….. Month/Year ___________ // ______

D. Chicken Pox (Varicella)

1. Documented case of Chicken Pox?…………………………………….. Yes     No  (circle one)

   Or . . .

2. Two doses of Varicella Vaccine ………………………………………….. Month/Year _______//_________

   If Neither . . .

3. Immune Titer: (Required) Result…… Positive ___   Negative ___ ……. Month/Year ___________ // ______

E. Tetanus/Pertussis (Within past 10 years)

1. Most recent Tetanus booster ……………………………………………… Month/Year ___________ // ______

2. One-time adult dose of Tdap (Required) …………………………………. Month/Year ___________ // ______

F. Influenza Vaccine: (Annual Requirement) ………………………………… Month/Year ___________ // ______

TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER

Name: __________________________________________ Address: __________________________________________

(Printed) Signature: __________________________ Phone: __________________________

Revised: 12/2016