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 by US Mail (address provided on the immunization form), by Email to: UMMS.Health.Records@umich.edu or Faxed to: (734) 764-9473.

Revised 12/2017
2018 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: (____)_____________ Date:

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

A. Hepatitis B Vaccination (Items 1 – 4 are required)
   1. .......................................................... Month/Year
   2. .......................................................... Month/Year
   3. .......................................................... Month/Year
   4. Antibody Titer: (Required – lab results must be included below)
      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, 2017 or later ………………… Month/Year
      (Re-test Annually)
   2. If PPD Positive, then QFT (Quantiferon Gold Test) dated November 1, 2017 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, 2017 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: 12/2017