



# Professional Student Immunization Requirements

## Vaccination and Screening Records

Enter dates and upload documentation for MMR, Tdap, Varicella, Hep B and Tuberculosis information into the secure 'New Professional Student Immunizations' tile via the secure [Occupational Health Services Portal](#). Ensure images of your documents are legible and include procedure name, dates, results, and identifying information (name on every page as well as the name of provider of care for that service).

Vaccination is essential for healthcare workers due to their increased exposure to infectious diseases. Staying current with vaccinations protects you from serious illnesses and helps prevent disease transmission to patients and the community. The Centers for Disease Control (CDC) emphasizes the importance of vaccinations in healthcare settings to safeguard both workers and patients. You may be considered for an Exception Request:

- [Vaccine - Religious exception](#)
- [Medical Exception](#)

Requirement					Status
<b>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.</b>					<b>Copy Attached</b>
<b>Option 1</b>	<b>Vaccine</b>	<b>Date</b>			
- 2 doses of MMR vaccine	MMR Dose #1	__ / __ / ____			
	MMR Dose #2	__ / __ / ____			
<b>Option 2</b>	<b>Vaccine or Test</b>	<b>Date</b>			
- 2 doses of Measles vaccine	Measles vaccine Dose #1	__ / __ / ____			
	Measles vaccine Dose #2	__ / __ / ____			
OR positive Measles serology	Serologic Immunity (IgG, antibodies, titer)	__ / __ / ____	Qualitative Titer Results: Quantitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative IU/ml	
- 2 doses of Mumps vaccine	Mumps vaccine Dose #1	__ / __ / ____			
	Mumps vaccine Dose #2	__ / __ / ____			
OR positive Mumps serology	Serologic Immunity (IgG, antibodies, titer)	__ / __ / ____	Qualitative Titer Results: Quantitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative IU/ml	
- 1 dose of Rubella vaccine	Rubella vaccine	__ / __ / ____			
OR positive Rubella serology	Serologic Immunity (IgG, antibodies, titer)	__ / __ / ____	Qualitative Titer Results: Quantitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative IU/ml	
<b>Tetanus-diphtheria-pertussis – One (1) dose of adult Tdap. Vaccine should be received on or after 11th birthday. If last Tdap was more than 10 years old, provide date of last Td and Tdap.</b>					
	Tdap Vaccine (Adacel, Boostrix, etc.)	__ / __ / ____			
	Td Vaccine (if more than 10 years since last Tdap)	__ / __ / ____			



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<b>Varicella (Chicken Pox) – 2 doses of vaccine or positive serology</b>					
	Varicella Vaccine #1	__ / __ / __			
	Varicella Vaccine #2	__ / __ / __			
<b>OR</b> positive Varicella serology	Serologic Immunity (IgG, antibodies, titer)		Qualitative Titer Results: Quantitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative  IU/ml	
<b>Hepatitis B Vaccination – 3 doses of Engergix-B, Recombivax or Twinrix or 2 doses of Heplisav-B followed by a positive Hepatitis B Surface Antibody (titer) preferably drawn 4-6 weeks after 3rd dose. If negative, give a 4th dose and repeat a titer in 4-6 weeks. If negative complete the remainder of the second series followed by another titer drawn 4-6 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.</b>					<b>Copy Attached</b>
<b>Primary Hepatitis B Series</b> Heplisav-B only requires 2 two doses of vaccine followed by antibody testing	3-dose vaccines (Engergix B, Recombivax or Twinrix) 2 dose vaccines (Heplisav-B)		<b>3 Dose Series</b>	<b>2 Dose Series</b>	
	Hepatitis B Vaccine Dose #1		/ /	/ /	
	Hepatitis B Vaccine Dose #2		/ /	/ /	
	Hepatitis B Vaccine Dose #3		/ /		
	Hep B Surface Antibody	__ / __ / __		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
<b>Secondary Hepatitis B Series</b> <u>Only if no response to primary series</u> Heplisav-B only requires 2 two doses of vaccine followed by antibody testing			<b>3 Dose Series</b>	<b>2 Dose Series</b>	
	Hepatitis B Vaccine Dose #4		/ /	/ /	
	Hepatitis B Vaccine Dose #5		/ /	/ /	
	Hepatitis B Vaccine Dose #6		/ /		
	Hep B Surface Antibody	__ / __ / __		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
<b>Hepatitis B Vaccine Non-responder</b> (If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)	Hepatitis B Surface Antigen	__ / __ / __		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Hepatitis B Core Antibody	__ / __ / __		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
<b>Chronic Active Hepatitis B</b>	Hepatitis B Surface Antigen	__ / __ / __		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Hepatitis B Viral Load	__ / __ / __		copies/ml	

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<p><b>TUBERCULOSIS SCREENING – HISTORY DEPENDENT. COMPLETE ONE SECTION ONLY.</b></p> <p><b>Section A: (History of Negative TB Screening)</b> At least one IGRA (QuantiFERON or T-SPOT) blood test performed <u>within three (3) months of first date on campus.</u></p> <p><b>Section B: (Two PPD Skin Tests)</b> Most recent performed <u>within three (3) months of first date on campus.</u></p> <p><b>Section C: (History of Positive TB Screening)</b> Documentation of positive testing, treatment if any, and a chest x-ray performed <u>within three (3) months of first date on campus.</u></p> <p><b>Section D: (History of Active TB Disease)</b> All fields completed. Chest x-ray must be performed <u>within three (3) months of first date on campus.</u></p>						
<b>Please complete only one TB section based on your history</b>	<b>Section A</b>		<b>Date</b>	<b>Result</b>	<b>Copy Attached</b>	
	T-Spot or QuantiFERON TB Gold blood tests for tuberculosis	<b>QuantiFERON TB Gold or T-Spot</b> <small>(Interferon Gamma Releasing Assay)</small>	__ / __ / __	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
		<b>QuantiFERON TB Gold or T-Spot</b> <small>(Interferon Gamma Releasing Assay)</small>	__ / __ / __	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
	<b>Section B</b>		<b>Date Placed</b>	<b>Date Read</b>	<b>Result</b>	
	Two PPD Skin Tests performed by either method	<b>Two PPD skin tests placed 7-31 days apart in the three months preceding entry into school.</b>	__ / __ / __ __ / __ / __	__ / __ / __ __ / __ / __	__ mm __ mm	
		<b>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.</b>	__ / __ / __ __ / __ / __	__ / __ / __ __ / __ / __	__ mm __ mm	
	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.					
	<b>Section C</b>		<b>Date Placed</b>	<b>Date Read</b>	<b>Result</b>	
	<b>History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test</b>  <small>IGRAs include T-Spots or QuantiFERON TB Gold blood</small>	Positive Test	__ / __ / __	__ / __ / __	__ mm	
				<b>Date</b>	<b>Result</b>	
<b>QuantiFERON TB Gold or T-Spot</b> <small>(Interferon Gamma Releasing Assay)</small>			__ / __ / __	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
Chest X-ray			__ / __ / __			
Treated for latent TB?				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	If treated for latent TB, list medications taken:					
	Total Duration of treatment latent TB?			__ Months		



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	<u>tests for tuberculosis</u>	Date of Last Annual TB Symptom Questionnaire	__ / __ / ____	
<b>Tuberculosis Screening History Continued</b>				
	<b>Section D</b>		<b>Date</b>	
	<b>History of Active Tuberculosis</b>	Date of Diagnosis	__ / __ / ____	<input type="checkbox"/>
		Date of Treatment Completed	__ / __ / ____	
		Date of Last Annual TB Symptom Questionnaire	__ / __ / ____	
		Date of Last Chest X-ray	__ / __ / ____	