Professional Student Immunization Requirements

<table>
<tr><td>COVID-19 Vaccination – Upload your COVID-19 records via the secure Occupational Health Services Portal. You must be logged into a UCSF network or sign on to Pulse Secure VPN. Find out how to access VPN here: https://it.ucsf.edu/service/vpn. You may also email your documentation to vaccineresponsibleoffice@ucsf.edu. The OHS portal is the central repository for the entire UCSF community COVID-19 vaccination data and used for compliance and reporting purposes.
WHO-EUL vaccines may also meet the requirements. Please see the drop-down list in https://myhealthrecord.ucsf.edu.</td><td>Copy Attached</td></tr>
<tr><td>Option 1</td><td></td></tr>
<tr><td>One or more of the following options:

• Initial shot or series (one-dose, such as the J&J vaccine) + ONE Booster (initial or bivalent)
• Bivalent Vaccine

AND

• XBB 1.5 Monovalent Vaccine Compliance (ONE of the options below)
    ○ Administration
    ○ Declination
    ○ Deferral</td><td></td></tr>
<tr><td>Option 2</td><td></td></tr>
<tr><td>Approved Exception Request:

*See Note Below re: Department of Public Health (DPS) sites

• COVID-19 Vaccine - Religious exception
• COVID-19 Medical Exception

AND

• XBB 1.5 Monovalent Vaccine Compliance (ONE of the options below)
    ○ Administration
    ○ Declination
    ○ Deferral

*NOTE: Vaccination is MANDATORY for all those working/training at a DPH site (SFDPH, CDPH, ZSFGH, etc.) NO EXCEPTIONS ARE PERMITTED to those working/training at these sites.</td><td></td></tr>
</table>

Professional Student Immunization Requirements

***Other Vaccination and Screening Records** – Enter dates and upload documentation for MMR, Tdap, Varicella, Hep B and Tuberculosis information into the secure 'Medical Clearances' module via the secure https://myhealthrecord.ucsf.edu 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).*

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.*					**Copy Attached**
Option 1	**Vaccine**	**Date**			
MMR - 2 doses of MMR vaccine	MMR Dose #1	__ / __ / ____			☐
	MMR Dose #2	__ / __ / ____			
Option 2	**Vaccine or Test**	**Date**			
Measles - 2 doses of vaccine	Measles vaccine Dose #1	__ / __ / ____			☐
	Measles vaccine Dose #2	__ / __ / ____			
OR positive Measles serology	Serologic Immunity (IgG, antibodies, titer)	__ / __ / ____	Qualitative Titer Results: Quantitative Titer Results:	☐ Positive ☐ Negative _____ IU/ml	
Mumps - 2 doses of vaccine	Mumps vaccine Dose #1	__ / __ / ____			☐
	Mumps vaccine Dose #2	__ / __ / ____			
OR positive Mumps serology	Serologic Immunity (IgG, antibodies, titer)	__ / __ / ____	Qualitative Titer Results: Quantitative Titer Results:	☐ Positive ☐ Negative _____ IU/ml	
Rubella - 1 dose of vaccine	Rubella vaccine	__ / __ / ____			☐
OR positive Rubella serology	Serologic Immunity (IgG, antibodies, titer)	__ / __ / ____	Qualitative Titer Results: Quantitative Titer Results:	☐ Positive ☐ Negative _____ IU/ml	
Tetanus-diphtheria-pertussis – *One (1) dose of adult Tdap. If last Tdap was more than 10 years old, provide date of last Td and Tdap.*					
	Tdap Vaccine (Adacel, Boostrix, etc.)	__ / __ / ____			☐
	Td Vaccine (*if more than 10 years since last Tdap*)	__ / __ / ____			
Varicella (Chicken Pox) – *2 doses of vaccine or positive serology*					
	Varicella Vaccine #1	__ / __ / ____			☐
	Varicella Vaccine #2	__ / __ / ____			
OR positive Varicella serology	Serologic Immunity (IgG, antibodies, titer)		Qualitative Titer Results: Quantitative Titer Results:	☐ Positive ☐ Negative _____ IU/ml	

Student Health
& Counseling
Student Academic Affairs

Professional Student Immunization Requirements

Hepatitis B Vaccination – *3 doses of Engergix-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 3rd dose. If negative, give a 4th dose and repeat a titer in 4-8 weeks. If negative complete the remainder of the second series followed by another titer drawn 4-8 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.*				**Copy Attached**
Primary Hepatitis B Series 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)	**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 <u>Only if no response to primary series</u> Heplisav-B only requires 2 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	☐

Professional Student Immunization Requirements

TUBERCULOSIS SCREENING – HISTORY DEPENDENT. COMPLETE ONE SECTION ONLY.

Section A: ***(History of Negative TB Screening)*** *At least one IGRA (QuantiFERON or T-SPOT) blood test performed within three (3) months of first date on campus.*

Section B: ***(History of Positive TB Screening)*** *Documentation of positive testing, treatment if any, and a chest x-ray performed within three (3) months of first date on campus.*

Section C: ***(History of Active TB Disease)*** *All fields completed. Chest x-ray must be performed within three (3) months of first date on campus.*

Tuberculosis Screening History

Please complete only one TB section based on your history

Section A		Date	Result	Copy Attached
T-Spot or QuantiFERON TB Gold blood tests for tuberculosis Use additional rows as needed	**QuantiFERON TB Gold or T-Spot** (Interferon Gamma Releasing Assay)	__ / __ / ____	◻ Negative ◻ Indeterminate	
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)	__ / __ / ____	◻ Negative ◻ Indeterminate	
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)	__ / __ / ____	◻ Negative ◻ Indeterminate	
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)	__ / __ / ____	◻ Negative ◻ Indeterminate	

Section B		Date Placed	Date Read	Result	Copy Attached
History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test IGRAs include T-Spots or QuantiFERON TB Gold blood tests for tuberculosis	Positive Test	__ / __ / ____	__ / __ / ____	___mm	
			Date	**Result**	
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing 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	__ / __ / ____	