



AAMC Standardized Immunization Form

Last Name:		First Name:		Middle Initial:	
DOB:		Street Address:			
Medical School:		City:			
Cell Phone:		State:			
Primary Email:		ZIP Code:			
Student ID:					

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				<input type="checkbox"/>
	MMR Dose #2				
Option 2	Vaccine or Test	Date			
Measles -2 doses of vaccine or positive serology	Measles Vaccine Dose #1		Serology Results		<input type="checkbox"/>
	Measles Vaccine Dose #2		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml	
Mumps -2 doses of vaccine or positive serology	Mumps Vaccine Dose #1		Serology Results		<input type="checkbox"/>
	Mumps Vaccine Dose #2		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml	
Rubella -1 dose of vaccine or positive serology	Rubella Vaccine		Serology Results		<input type="checkbox"/>
	Serologic Immunity (IgG antibody titer)		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
			Quantitative Titer Results:	_____ IU/ml	
Tetanus-diphtheria-pertussis – One (1) dose of adult Tdap. If last Tdap is more than 10 years old, provide dates of last Td and Tdap					
	Tdap Vaccine (Adacel, Boostrix, etc)				<input type="checkbox"/>
	Td Vaccine (if more than 10 years since last Tdap)				
Varicella (Chicken Pox) - 2 doses of vaccine or positive serology					
	Varicella Vaccine #1		Serology Results		<input type="checkbox"/>
	Varicella Vaccine #2		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml	
Influenza Vaccine - 1 dose annually each fall					
Date of last dose		Date			<input type="checkbox"/>
	Flu Vaccine				
COVID-19 Vaccine - primary series of two (2) doses and booster dose		Date	Company or Trade Name		
	COVID-19 Vaccine #1				<input type="checkbox"/>
	COVID-19 Vaccine #2				
	COVID-19 Booster Bivalent Vaccine				

AAMC Standardized Immunization Form

Name: _____ Date of Birth: _____
 (Last, First, Middle Initial) (mm/dd/yyyy)

Hepatitis B Vaccination - 3 doses of <i>Enerix-B, PreHevbrio, Recombivax HB or Twinrix</i> vaccines or 2 doses of <i>Heplisav-B</i> vaccine followed by a QUANTITATIVE Hepatitis B Surface Antibody test drawn 4-8 weeks after last vaccine dose. A test titer ≥ 10 mIU/mL is positive for immunity. If the test result is negative, CDC guidance recommends that HCP receive one or more additional doses of Hepatitis B vaccine up to completion of a second series, followed by a repeat titer test 4-8 weeks after the last vaccine dose. If a single additional vaccine dose does not elicit a positive test result, administer additional vaccine doses to complete the second series using the schedule approved for the primary series of a given product. If the Hepatitis B Surface Antibody test is negative (< 10 mIU/mL) after receipt of 2 complete vaccine series, a "non-responder" status is assigned. See: http://dx.doi.org/10.15585/mmwr.rr6701a1 for additional information.				Copy Attached
Primary Hepatitis B Series Heplisav-B only requires two doses of vaccine followed by antibody testing	3-dose vaccines (<i>Energix-B, PreHevbrio, Recombivax HB, Twinrix</i>) or 2-dose vaccine (<i>Heplisav-B</i>)	3 Dose Series	2 Dose Series	<input type="checkbox"/>
	Hepatitis B Vaccine Dose #1			
	Hepatitis B Vaccine Dose #2			
	Hepatitis B Vaccine Dose #3			
	QUANTITATIVE Hep B Surface Antibody Test		_____ mIU/ml	
Additional doses of Hepatitis B Vaccine <u>Only If no response to primary series</u> Heplisav-B only requires two doses of vaccine followed by antibody testing		3 Dose Series	2 Dose Series	<input type="checkbox"/>
	Hepatitis B Vaccine Dose #4			
	Hepatitis B Vaccine Dose #5			
	Hepatitis B Vaccine Dose #6			
	QUANTITATIVE Hep B Surface Antibody Test		_____ mIU/ml	
Hepatitis B Vaccine Non-responder	If the Hepatitis B Surface Antibody test is negative (titer less than 10 mIU/mL) after a primary and repeat vaccine series, vaccine non-responders should be counseled and evaluated appropriately. Certain institutions may request signing an "acknowledgement of non-responder status" document before clinical placements.			
Additional Documentation				
<u>Some institutions</u> may have additional requirements depending upon rotation, school requirements or state law. Examples include meningitis vaccine which is mandated in some states if you live in dormitory style housing. If you will be participating in an international experience, you may also be required to provide proof of vaccines such as yellow fever or typhoid.				
Vaccination, Test or Examination	Date	Result or Interpretation		
Physical Exam (if required)				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>



AAMC Standardized Immunization Form

Name: _____ Date of Birth: _____
 (Last, First, Middle Initial) (mm/dd/yyyy)

TUBERCULOSIS (TB) SCREENING – All U.S. healthcare personnel are screened pre-placement for TB. Results of the last (2) TB Skin Tests (TSTs) or (1) IGRA blood test are required **regardless** of prior BCG status. The 2-step TST protocol must have been placed within the past 12 months prior to clinical duties, and must have been performed in the U.S. The second TST must be placed at least 1 week after the first TST read date. If you have a history of a positive TST (PPD) ≥ 10 mm or a positive IGRA blood test, please supply information regarding any evaluation and/or treatment below. You only need to complete ONE section, A or B.

Skin test or IGRA results should not expire during proposed elective rotation dates
or
must be updated with the receiving institution prior to rotation.

Tuberculosis Screening History

Please complete only one TB section based on your history

Section A	Date Placed	Date Read	Result	Interpretation	
History of Negative TB Skin Test or Blood Test <small>T-spots or QuantiFERON TB Gold blood tests for tuberculosis</small> <small>Use additional rows as needed</small>	TST #1		____ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	
	TST #2		____ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	
			Date	Result	
		QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>			<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate
		QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>			<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate
Section B	Date Placed	Date Read	Result		
History of Positive Skin Test or Positive Blood Test	Positive TST		____ mm		
			Date	Result	
		QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>			<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate
	Chest X-ray*			*Provide documentation or result	
	Treated for latent TB infection (LTBI)?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Date of Last Annual TB Symptom Questionnaire			



AAMC Standardized Immunization Form

Name: _____ Date of Birth: _____
(Last, First, Middle Initial) (mm/dd/yyyy)

Additional Information

MUST BE SIGNED BY A LICENSED HEALTHCARE PROFESSIONAL OR DESIGNEE:

Healthcare Professional Signature:		Date:
Printed Name:		Office Use Only
Title:		
Address Line 1:		
Address Line 2:		
City:		
State:		
Zip:		
Phone: () - Ext:		
Fax: () -		
Email Contact:		

*Sources:

- [Hepatitis B In: Centers for Disease Control and Prevention. Epidemiology and Prevention of Vaccine-Preventable Diseases. Hamborsky J, Kroger A, Wolfe S, eds. 13th ed. Washington D.C. Public Health Foundation, 2015](#)
- [Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices \(ACIP\), MMWR, Vol 60\(7\):1-45](#)
- [CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management, MMWR, Vol 62\(RR10\):1-19](#)
- [Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices, MMWR Vol 67\(1\):1-31](#)
- [Sosa LE, Nijie GL, Lobato MN, et.al. Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from National Tuberculosis Controllers Association and CDC, 2019. MMWR2019;68:439-443. \[https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s_cid=mm6819a3_w\]\(https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s_cid=mm6819a3_w\)](#)