

UNIVERSITY OF CALIFORNIA, LOS ANGELES IMMUNIZATION REQUIREMENTS

Student ID:	Name: LAST FIRST
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REQUIRED IMMUNIZATIONS	
Tdap Vaccine <ul style="list-style-type: none"> • Tetanus/Diphtheria WITH Pertussis (whooping cough) 	<p>ONE DOSE ON OR AFTER AGE 7YRS FOR NON-Healthcare Professional Students</p> <p>ONE DOSE IN THE LAST 10YRS required for Healthcare Professional Students</p> <p>Dose Date: _____</p> <p>(Please note: The requirement is Tdap and not Td or Dtap)</p>
MMR Vaccine <ul style="list-style-type: none"> • Measles, Mumps & Rubella 	<p>YOU MUST HAVE 2 DOSES WITH THE FIRST DOSE BEING ON OR AFTER YOUR FIRST BIRTHDAY.</p> <p>Dose 1 Date: _____ (must be on or after your 1st birthday)</p> <p>(Dose 1 & 2 must be AT LEAST 28 days apart)</p> <p>Dose 2 Date: _____</p> <p>IF UNABLE TO OBTAIN PROOF OF VACCINATION YOU MUST OBTAIN A BLOOD TITER TEST.</p> <p>* ATTACH A COPY OF YOUR LAB REPORT.</p> <p>POSITIVE Measles IgG Antibody Titer Titer Date: _____</p> <p>POSITIVE Mumps IgG Antibody Titer Titer Date: _____</p> <p>POSITIVE Rubella IgG Antibody Titer Titer Date: _____</p> <ul style="list-style-type: none"> • If you have a negative or indeterminate titer, obtain one dose of MMR and repeat titer 4 wks later. If titer is still negative, receive a 2nd dose of MMR.
Varicella (Chicken Pox) Vaccine	<p>YOU MUST HAVE 2 DOSES WITH THE FIRST DOSE BEING ON OR AFTER YOUR FIRST BIRTHDAY.</p> <p>Dose 1 Date: _____ (must be on or after your 1st birthday)</p> <p>(Dose 1 & 2 must be AT LEAST 28 days apart)</p> <p>Dose 2 Date: _____</p> <p>IF YOU HAD THE DISEASE AS A CHILD OR IF YOU ARE UNABLE TO OBTAIN PROOF OF VACCINATION, YOU MUST OBTAIN A BLOOD TITER TEST.</p> <p>POSITIVE Varicella IgG Antibody Titer Titer Date: _____</p> <ul style="list-style-type: none"> • If you have a negative or indeterminate titer, obtain one dose of varicella vaccine and repeat titer 4 wks later. If titer is still negative, receive a 2nd dose of varicella.
Meningococcal Vaccine <ul style="list-style-type: none"> • MCV4 (Menactra or Menveo preferred) for students 21 yrs or younger 	<p>THE MOST RECENT DOSE MUST BE ON OR AFTER THE 16TH BIRTHDAY.</p> <p>Dose 1 Date: _____</p> <p>Dose 2 Date: _____</p>

TUBERCULOSIS (TB) HEALTH ASSESSMENT FORM UNIVERSITY OF CALIFORNIA, LOS ANGELES

Student ID:	Date of Birth: (MM/DD/YYYY)	Name: First	Last
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For incoming students who answered "YES" to any of the questions on the *Tuberculosis Risk Screening Questionnaire* on the Ashe Secure Portal

OR

If you are a Healthcare Professional Student (Medical/Dental/Nursing/Social Welfare) please complete section below:

TUBERCULIN SKIN TEST (TST)	OR	TB BLOOD TEST (Recommended if history of BCG/TB Vaccine)
<p>One skin test required for NON-Healthcare Professional Students: Date placed: _____ Date read: _____ (must be read between 48-72hrs after it was placed) Result: _____ mm induration. Interpretation: <input type="checkbox"/> Negative <input type="checkbox"/> Positive (IF POSITIVE, PROCEED TO SYMPTOMS & BLOOD TEST OR CHEST X-RAY)</p>		<p>QUANTIFERON or T-SPOT (Interferon Gamma Release Assay – IGRA) If not available, may do a Tuberculin Skin Test (TST) or Chest X-ray. Date QTF/T-SPOT Test: _____ Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive (IF POSITIVE, PROCEED TO SYMPTOMS & CHEST X-RAY) <input type="checkbox"/> Indeterminate (IF INDETERMINATE, REPEAT TEST OR PROCEED TO CHEST X-RAY)</p>
<p>Two skin tests required for Healthcare Professional Students: Date placed: _____ Date read: _____ (must be read between 48-72hrs after it was placed) Result: _____ mm induration. Interpretation: <input type="checkbox"/> Negative <input type="checkbox"/> Positive (IF POSITIVE, PROCEED TO SYMPTOMS & BLOOD TEST OR CHEST X-RAY)</p>		
<p>SYMPTOMS: Does your patient have any of the following symptoms? (please check any that apply) <input type="checkbox"/> Cough for greater than 4wks <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Unexplained Chest pain <input type="checkbox"/> Persistent fever/chills/night sweats <input type="checkbox"/> Persistent, unexplained fatigue <input type="checkbox"/> Unexplained weight loss</p>		
<p>CHEST X-RAY (REQUIRED if TST or Quantiferon/IGRA +/-or Symptoms are positive OR previous treatment for TB)</p>		
<p>Date of Chest x-ray: _____ Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal MUST ATTACH <u>WRITTEN</u> RADIOLOGY CHEST XRAY REPORT IN ENGLISH (DO NOT SEND FILMS/CD of actual X-ray)</p>		

MD/PA/NP	Signature	(MM/DD/YYYY)
_____	_____	_____
Licensed Health Care Provider Name	Signature	Date

ADDITIONAL REQUIREMENTS FOR ALL HEALTHCARE PROFESSIONAL SCHOOL STUDENTS (MEDICAL/NURSING/DENTAL/SOCIAL WELFARE)

Hepatitis B Immunity

All students must have a series of three Hepatitis B vaccinations (initial dose, dose two at 1 month, and dose three at 6 months). A post-vaccine surface antibody titer (to demonstrate immunity) is **required** one month after 3rd vaccine dose.

Dose #1 ____/____/____ (MM/DD/YR)

Dose #2 ____/____/____ (MM/DD/YR) Dose

#2 ____/____/____ (MM/DD/YR)

Hep B surface antibody titer: Reactive: Non-Reactive: Date: ____/____/____

*If antibody non-reactive, Hepatitis B surface antigen is required prior to repeat series.

Hep B surface antigen titer: Reactive: Non-Reactive: Date: ____/____/____

If Hep B surface antigen is negative, get Hepatitis B vaccine booster. Repeat titer one month later.

Dose #4 ____/____/____ (MM/DD/YR)

2nd Hep B surface antibody titer: Reactive: Non-Reactive: Date: ____/____/____

*If repeat Hep B surface antibody is non-reactive, continue with 2nd series and then check titer one month later.

Dose #5 ____/____/____ (MM/DD/YR)

Dose #6 ____/____/____ (MM/DD/YR)

3rd Hep B surface antibody titer: Reactive: Non-Reactive: Date: ____/____/____

*If repeat Hep B surface antibody is non-reactive, please schedule with an Ashe Center clinician to discuss.

Annual Influenza Vaccine

MUST BE GIVEN AFTER AUGUST OF ENTERING YEAR

Dose Date: ____/____/____

STRONGLY RECOMMENDED IMMUNIZATIONS	*NOTE: These vaccinations are recommended BUT NOT required to be compliant with enrollment	
HPV Vaccine <ul style="list-style-type: none"> Human Papilloma Virus Vaccine 3 dose series 	RECOMMENDED FOR ALL STUDENTS (ALL GENDERS) UP TO THE AGE OF 26 HPV 4 Dose 1 Date: _____ Dose 2 Date: _____ Dose 3 Date: _____	RECOMMENDED FOR ALL STUDENTS (ALL GENDERS) UP TO THE AGE OF 26 HPV 9 Dose 1 Date: _____ Dose 2 Date: _____ Dose 3 Date: _____
Meningococcal B Vaccine <ul style="list-style-type: none"> Trumemba or Bexsero 	RECOMMENDED FOR AGES 16 – 23YRS AFTER DISCUSSION WITH A HEALTHCARE PROVIDER Dose 1 Date: _____ Dose 2 Date: _____ (Trumemba is either a 2 dose or 3 dose series. Bexsero is a 2 dose series) Dose 3 Date: _____	
Hepatitis A Vaccine <ul style="list-style-type: none"> 2 dose series 	Dose 1 Date: _____ (Dose 2 must be at LEAST 6 mths following first) Dose 2 Date: _____	
Polio Vaccine <ul style="list-style-type: none"> 4 dose series 	Dose 1 Date: _____ Dose 2 Date: _____ Dose 3 Date: _____ Dose 4 Date: _____	
Pneumococcal Vaccine <ul style="list-style-type: none"> PCV13 +/- PPSV23 based on health history 	Dose PCV13 Date: _____ Dose PPSV23 Date: _____ <ul style="list-style-type: none"> Only recommended for those with a history of asthma, diabetes, smokers and those with immunosuppression due to illness or medication after discussion with your healthcare provider 	

I ATTEST THAT ALL DATES AND IMMUNIZATIONS LISTED ON THIS FORM ARE CORRECT AND ACCURATE	
Provider's Signature: _____	Practice Stamp: _____
Provider's Name: _____ (Physician/PA/NP/RN)	Date: _____