UCSF Visiting Student Immunization Form 2019

Student Name _____ Date of Birth _____ Signature _____

Email address_____ School_____

TB Skin Testing (must meet either A **or** B **or** C or D below)

- A **PPD skin test** must be placed the SAME day as a **live virus vaccine** OR at least 30 days after the administration of a live virus vaccine to be considered valid.

A. If you have a **negative** skin test

If you have had annual TB skin testing: submit documentation of a PPD skin test **within a year of rotation start date**

TEST : mm reading _____ **Date:** _____/_____/_____

B. If you have a past **positive** skin test**:**

Positive skin test:
mm reading _____ Date: _____/_____/_____

Chest x-ray report: required
(Current CXR since starting medical school unless 6+ months of INH therapy completed)

x-ray results: θ normal θ abnormal

Date: _____/_____/_____

INH therapy taken:

θ yes θ no

Date started: ____/____/____ Date ended: ____/____/____

length of treatment _____ months

C. QuantiFERON Gold test – Negative test results only

There are instances where your provider might run a QuantiFERON lab test to establish PPD negative status: submit documentation of a QuantiFERON Gold test reported within current school year.

If you have a positive QuantiFERON lab test, you must submit a recent chest x-ray as shown in box B above.

Negative QuantiFERON Date: _____/_____/_____

D. T-SPOT test results only

Submit documentation of a **negative** T-SPOT test result reported within current school year.

If you have a positive T-SPOT lab test, you must submit a recent chest x-ray as shown in box B above.

Negative T-SPOT Date: _____/_____/_____

Measles (Rubeola): Positive Titer **REQUIRED**

- If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer. If titer is still negative, contact your healthcare provider.

1) **Positive** measles titer

Date: _____/_____/_____

Mumps: Positive Titer **REQUIRED**

- If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer. If titer is still negative, contact your healthcare provider.

1) **Positive** mumps titer

Date: _____/_____/_____

Rubella (German Measles): Positive Titer **REQUIRED**

- If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer. If titer is still negative, contact your healthcare provider.

1) Positive rubella titer

Date: _____/_____/_____

Varicella: Positive Titer **REQUIRED**
(History of disease is **NOT** sufficient)

- If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer. If titer is still negative, contact your healthcare provider.

1) **Positive** varicella titer

Date: _____/_____/_____

Hepatitis B: Positive Titer **REQUIRED**

A. **Received vaccination and titer didn't convert to positive**: If you have completed the Hep B series of 3 immunizations and your titer doesn't convert to reactive/positive, you must obtain and submit the date for a 4th dose of Hep B, then re-titer. Also submit the date of the previous three immunizations and negative/non-reactive titer. If you have already received two full course of Hep B vaccination (6 doses – 2 series of 3 shots) submit the dates of ALL doses of vaccine and negative titer.

OR

B. **History of Hep B infection**: **Core antibody & surface antigen titer results** (these titers submitted in instance of prior infection). Only positive titers reflect history of past disease. If these titers are negative you should be immunized and obtain the surface antibody titer.

Revised 2/2017

1) Positive Hepatitis B surface Ab titer **Date:** _____/_____/_____	**OR**	**2)** Previous infection - Need core antibody & surface antigen titers **Date:** _____/_____/_____ **Hep B core Ab titer** **Date:** _____/_____/_____ **Hep B surface antigen**

TB Questions - Required

TB Screening Questions **REQUIRED**

Have you ever received BCG?	θ yes	θ no	**if yes:** Year _____ Country _____
Have you traveled and/or lived overseas in the past year?	θ yes	θ no	**if yes:** Countries _____
Have you worked in a prison or homeless shelter in the past year?	θ yes	θ no	
Have you entered a TB isolation room in the past year?	θ yes	θ no	
Have you had exposure to a known case of TB in the past year?	θ yes	θ no	
In the past six months have you experienced any of the following for greater than three weeks?			
Excessive sweating at night	θ yes	θ no	
Excessive weight loss	θ yes	θ no	
Coughing up blood	θ yes	θ no	
Excessive Fatigue	θ yes	θ no	
Hoarseness	θ yes	θ no	
Persistent coughing	θ yes	θ no	
Persistent fever	θ yes	θ no	

Tetanus/Diphtheria/Pertussis/ (Tdap) and Seasonal Flu Vaccine

Tdap (Tetanus Diphtheria Pertussis) **Date:** ___/___/___

- Vaccine must be Tdap, not Td.
- Tdap is required regardless of date of last Td injection.

Seasonal Flu Vaccine Date: ___/___/___

- **Must have most current vaccine (new vaccine available around September of each year)**

I attest that all dates and immunizations listed above are correct and accurate.

Provider's Signature _____ Date _____
Physician, Nurse Practitioner, Physician's Assistant, or RN

Provider's name printed _____Phone number _____
Physician, Nurse Practitioner, Physician's Assistant, or RN

Clinic Stamp – If the verifying provider's office has clinic stamp, please place here.