Guide to Completing The Standardized Immunization Form

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:					

Reminder: ⇨
If MMR Dose #1 is before 1 year of age, you MUST re-vaccinate with a two dose series OR provide proof of immunity (preferred).

⇦ Reminder:
Don't forget to submit supporting documents for each required immunization.

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 or positive serology*	Measles Vaccine Dose #1		**Serology Results**	
	Measles Vaccine Dose #2		Qualitative Titer Results: ❑ Positive ❑ 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**	
	Mumps Vaccine Dose #2		Qualitative Titer Results: ❑ Positive ❑ Negative	☐
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results: _____ IU/ml	
Rubella *-1 dose of vaccine or positive serology*			**Serology Results**	
	Rubella Vaccine		Qualitative Titer Results: ❑ Positive ❑ Negative	☐
	Serologic Immunity (IgG antibody titer)		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)			☐
	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**	
	Varicella Vaccine #2		Qualitative Titer Results: ❑ Positive ❑ Negative	☐
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results: _____ IU/ml	
Influenza Vaccine - *1 dose annually each fall*				
Date of last dose		**Date**		☐
	Flu Vaccine			
COVID-19 Vaccine - *1 dose of updated 2024-2025 COVID-19 vaccine if previously vaccinated with any COVID-19 Vaccine, administered ≥8 weeks after the last dose.*		**Date**		
	Pfizer-BioNTech COVID-19 vaccine			
	or Moderna COVID-19 vaccine			☐
	or Novavax COVID-19 vaccine (aged >12 yrs only)			

Reminder: ⇨
TDAP on or after age 11 is required.

Additional TDAP is needed if TDAP was given over 10 years ago.

Reminder: ⇨
The Influenza Vaccine season is September–April.

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Hepatitis B Vaccination - *3 doses of Engerix-B, PreHevbrio, Recombivax HB or Twinrix vaccines or 2 doses of Heplisav-B vaccine followed by a **QUANTITATIVE** Hepatitis B Surface Antibody test drawn 4-8 weeks after last vaccine dose. A test titer ≥10mIU/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 (Energix-B, PreHevbrio, Recombivax HB, Twinrix) or 2-dose vaccine (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 Test		_____ mIU/ml	
Additional doses of Hepatitis B Vaccine *Only If no response to primary series* Heplisav-B only requires 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 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.			

⇦ Reminder:
Be sure to submit your QUANTITATIVE titer.

Additional Documentation			
Some institutions *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)			

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TUBERCULOSIS (TB) SCREENING – *All U.S. healthcare personnel are screened pre-placement for TB. Two kinds of tests are used to determine if a person has been infected with TB bacteria: the TB skin test (TST) and the TB blood test (IGRA). Results of the last two TSTs or one IGRA blood test are required **regardless** of prior BCG status. If the TST method is used, record the dates and results of two 1-step annual TSTs over the last two years, or of one 2-step TST protocol (two TSTs performed with the second TST placed at least 1 week after the first TST read date). In either series, the second TST must have been placed within the past 12 months prior to clinical duties, and must have been performed in the U.S. If you have a history of a positive TST (PPD) >10mm or a positive IGR 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	**TST #1**			____ mm	❑ Pos ❑ Neg ❑ Equiv
	TST #2			____mm	❑ Pos ❑ Neg ❑ Equiv
			Date	**Result**	
T-spots or QuantiFERON TB Gold blood tests for tuberculosis Use additional rows as needed	**QuantiFERON TB Gold or T-Spot** (Interferon Gamma Releasing Assay)			❑ Positive ❑ Negative ❑ Indeterminate	
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)			❑ Positive ❑ Negative ❑ 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 (Interferon Gamma Releasing Assay)			❑ Positive ❑ Negative ❑ Indeterminate
	Chest X-ray*			*Provide documentation or result
	Treated for **latent** TB infection (LTBI)?			❑ Yes ❑ No
	Date of Last Annual TB Symptom Questionnaire			

⇦ Reminder:

IGRA (blood) test needs to be completed within 12 months of your clinical rotation.

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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:

1. Haber P, Schille S. Chapter 10: Hepatitis B Pink Book. CDC https://www.cdc.gov/pinkbook/hcp/table-of-contents/chapter-10-hepatitis-b.html?CDC_AAref_Val=https://www.cdc.gov/vaccines/pubs/pinkbook/hepb.html
2. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP), MMWR, Vol 60(7):1-45
3. CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management, MMWR, Vol 62(RR10):1-19
4. Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices, MMWR Vol 67(1):1-31
5. 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