



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	
	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	
	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	
			Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> 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)	_/_/___	<input type="checkbox"/>	
	Td Vaccine (if more than 10 years since last Tdap)	_/_/___		
Varicella (Chicken Pox) - 2 doses of vaccine or positive serology				
Varicella (Chicken Pox)	Varicella Vaccine #1	_/_/___	Serology Results	
	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	_/_/___		



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Hepatitis B Vaccination - 3 doses of <i>Energix-B, Recombivax 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, repeat another Hepatitis B vaccine series followed by a repeat test titer. If the Hepatitis B Surface Antibody test is negative after the repeat vaccine series, a "non-responder" status is assigned. See: http://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf for more information.				Copy Attached
Primary Hepatitis B Series <small>Heplisav-B only requires two doses of vaccine followed by antibody testing</small>	3-dose vaccines (<i>Energix-B, Recombivax, Twinrix</i>) 2-dose vaccines (<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	
Repeat Hepatitis B Series <small>Heplisav-B only requires two doses of vaccine followed by antibody testing</small> <u>Only If no response to primary series</u>		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.			<input type="checkbox"/>
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"/>
	___/___/___			
	___/___/___			
	___/___/___			
	___/___/___			
	___/___/___			
	___/___/___			

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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) \geq 10mm 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	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	
	T-spots or QuantiFERON TB Gold blood tests for tuberculosis Use additional rows as needed			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					___/___/___		



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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:

- [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?cid=mm6819a3 w](#)