



# AAMC Standardized Immunization Form

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

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



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<b>Hepatitis B Vaccination</b> - 3 doses of <i>Engerix-B, PreHevbrio, Recombivax</i> or <i>Twinrix</i> vaccines or 2 doses of <i>Heplisav-B</i> vaccine followed by a <b>QUANTITATIVE</b> Hepatitis B Surface Antibody test drawn 4-8 weeks after last vaccine dose. A test titer $\geq 10$ 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: <a href="http://www.cdc.gov/mmwr/pdf/rr/r6210.pdf">http://www.cdc.gov/mmwr/pdf/rr/r6210.pdf</a> for more information.				Copy Attached
<b>Primary Hepatitis B Series</b>  <small>Heplisav-B only requires two doses of vaccine followed by antibody testing</small>	3-dose vaccines ( <i>Energix-B, PreHevbrio, Recombivax, 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			
	<b>QUANTITATIVE</b> Hep B Surface Antibody Test		_____ mIU/ml	
<b>Repeat Hepatitis B Series</b>  <u>Only If no response to primary series</u>  <small>Heplisav-B only requires two doses of vaccine followed by antibody testing</small>		3 Dose Series	2 Dose Series	
	Hepatitis B Vaccine Dose #4			
	Hepatitis B Vaccine Dose #5			
	Hepatitis B Vaccine Dose #6			
	<b>QUANTITATIVE</b> Hep B Surface Antibody Test		_____ mIU/ml	
<b>Hepatitis B Vaccine Non-responder</b>	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.			
<b>Additional Documentation</b>				
<i>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.</i>				
<b>Vaccination, Test or Examination</b>		<b>Date</b>	<b>Result or Interpretation</b>	
Physical Exam (if required)				



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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)  $\geq 10$ 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
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
<b>History of Negative TB Skin Test or Blood Test</b>  <small>T-spots or QuantiFERON TB Gold blood tests for tuberculosis</small>  <small>Use additional rows as needed</small>				
		<b>Date</b>	<b>Result</b>	
	<b>QuantiFERON TB Gold or T-Spot</b> (Interferon Gamma Releasing Assay)			<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate
	<b>QuantiFERON TB Gold or T-Spot</b> (Interferon Gamma Releasing Assay)			<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate
<b>Section B</b>	<b>Date Placed</b>	<b>Date Read</b>	<b>Result</b>	
<b>History of Positive Skin Test or Positive Blood Test</b>	Positive TST		___ mm	
		<b>Date</b>	<b>Result</b>	
	<b>QuantiFERON TB Gold or T-Spot</b> (Interferon Gamma Releasing Assay)			<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:**

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

\*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. \[https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s\\\_cid=mm6819a3\\\_w\]\(https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s\_cid=mm6819a3\_w\)](#)