University of CINCINNATI

**Health Professions Programs:**

Advanced Medical Imaging (AMIT), Athletic Training, College of Medicine (MD) , College of Pharmacy, Communication Sciences & Disorders, Dental Hygiene, Medical Assistant, Medical Laboratory Sciences, Medical Sciences, Radiologic Technology

**Name:** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

**Student ID:** M ___ ___ ___ ___ ___ ___ ___ ___ **Birthdate:**_____ / _____ / _____

**To be completed by personal health care provider and then uploaded in full to secure.medproctor.com**

| | Required Vaccines for classes (MMDDYY) | | Serological proof of immunity. |
|---|---|---|---|
| check one ☐ ☐ | **Hepatitis B ( 3 required)**<br>**OR**<br>**HEPLISAV-B (2 required)** **Primary Series** | **AND** | **Quantitative HBSAB titer date and result**<br>**Required:** Upload lab report<br>_____ / _____ / _____ quantitative result: _____<br>Quantitative HBSAB titer date reactive ◯ non-reactive ◯<br>If HBSAB result is ** non-reactive, a booster is required, then repeat titer four weeks later. |
| 1st | _____ / _____ / _____ | | |
| 2nd | _____ / _____ / _____ | | |
| 3rd | _____ / _____ / _____ | | |
| check one ☐ ☐ | **Hepatitis B**<br>**OR**<br>**HEPLISAV-B** **Additional Booster or Secondary Series** | **AND** | **Quantitative HBSAB titer date(s) and result(s) if applicable**<br>**Required:** Upload lab report(s)<br>_____ / _____ / _____ quantitative result: _____<br>Quantitative HBSAB titer date reactive ◯ non-reactive ◯<br>If repeat titer is non-reactive finish entire second series and repeat titer four weeks later.<br>_____ / _____ / _____ quantitative result: _____<br>Second series HBSAB titer date reactive ◯ non-reactive ◯ |
| 1st | _____ / _____ / _____ | | |
| 2nd | _____ / _____ / _____ | | |
| 3rd | _____ / _____ / _____ | | |
| | **MMR[1] ( 2 required)** | **OR** | **MMR titer and result** ***Required:*** *Upload lab report* |
| 1st | _____ / _____ / _____ | | Measles titer date: _____ / _____ / _____ result: ◯ negative ◯ positive |
| 2nd | _____ / _____ / _____ | | |
| | | | Mumps titer date: _____ / _____ / _____ result: ◯ negative ◯ positive |
| | | | Rubella titer date: _____ / _____ / _____ result: ◯ negative ◯ positive |
| | **Meningococcal (A) Quadrivalent required for students who are 16-21 years of age.** (one required on/after 16th birthday) | | |
| | _____ / _____ / _____ | | |
| | **Influenza (flu) (*required each fall)** | | |
| | _____ / _____ / _____ | | |

* Flu vaccine due by October 22nd, unless otherwise specified by your program

** The AAMC recommends a complete second Hep B series if the intial titer is non-reactive. It is your responsibility to determine if your clinical site follows the AAMC recommendation.

1 MMR = Measles, Mumps, Rubella

2 Tdap = Adult dose, Tetanus, Diptheria, Accellular Pertussis

3 Td = Adult dose. Tetanus Diptheria (given if it has been longer than 10 years since Adult dose of Tdap)

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**Student ID:** M ___ ___ ___ ___ ___ ___ ___ ___ **Birthdate:** _____ / _____ / _____

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| | **Required Vaccines for classes (MMDDYY)** | | **Serological proof of immunity.** |
|---|---|---|---|
| | **Two Mantoux Tuberculin Skin Tests** (2-step TB or PPD) placed 7 to 30 days apart (then annual tuberculosis screening) | **OR** | **IGRA blood tests results (QuantiFERON or T-Spot) (then annual tuberculosis screen)**<br>Date of TB Blood Test<br>_____ / _____ / _____ result: ○ negative ○ positive<br>***Required:*** *Upload lab report* |
| Placed<br>Read | **Step 1) 1st TB Skin Test (PPD)**<br>_____ / _____ / _____<br>_____ / _____ / _____ | | **CHEST X-RAY**<br>If IGRA is positive, enter Chest X-Ray results (within previous 12 months) below.<br>Note: In lieu of PPD skin testing or IGRA blood testing, a normal chest x-ray (within the previous 12months ) may meet the requirement.<br>Date of Chest X-Ray<br>_____ / _____ / _____ result: ○ negative ○ positive<br>***Required:*** *Upload x-ray report* |
| Induration | _____ _____ mm (record actual induration in millimeters) | | |
| Placed<br>Read | **Step 2) 2nd TB Skin Test (PPD)**<br>_____ / _____ / _____<br>_____ / _____ / _____ | | |
| Induration | _____ _____ mm (record actual induration in millimeters) | | |
| | **Tdap** (Adult dose,Tetanus,Diptheria, Accellular Pertussis) One adult Tdap booster given after 2006. If Tdap adult booster was given > than 10 years ago then a current Td adult booster is also required. | | |
| 1st<br>2nd | _____ / _____ / _____ **(²Tdap)**<br>*And*<br>_____ / _____ / _____ **(³Td)**<br>**(if Tdap > than 10 years ago)** | | |
| | **Varicella ( 2 required)** | **OR** | **VZV IgG titer** ***Required:*** *Upload lab report*<br>VZV IgG titer date _____ / _____ / _____<br>result: ○ negative ○ positive |
| 1st | _____ / _____ / _____ | | |
| 2nd | _____ / _____ / _____ | | |

| Licensed Professional's Name | Licensed Professional's Signature | Signature Date<br>_____ / _____ / _____ |
|---|---|---|
| **Office Stamp Preferred**/Address And Provider NPI (Required If No Office Stamp) | Office email | Office Phone Number |