

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 | <input type="checkbox"/> | Hepatitis B (3 required) OR Primary Series | AND | Quantitative HBSAB titer date and result Required: Upload lab report _____ / _____ / _____ quantitative result: _____ Quantitative HBSAB titer date reactive <input type="radio"/> non-reactive <input type="radio"/> If HBSAB result is ** non-reactive, a booster is required, then repeat titer four weeks later. |
| | <input type="checkbox"/> | HEPLISAV-B (2 required) | | |
| | 1st | _____ / _____ / _____ | | |
| | 2nd | _____ / _____ / _____ | | |
| | 3rd | _____ / _____ / _____ | | |
| check one | <input type="checkbox"/> | Hepatitis B OR Additional Booster or Secondary Series | AND | Quantitative HBSAB titer date(s) and result(s) if applicable Required: Upload lab report(s) _____ / _____ / _____ quantitative result: _____ Quantitative HBSAB titer date reactive <input type="radio"/> non-reactive <input type="radio"/> If repeat titer is non-reactive finish entire second series and repeat titer four weeks later. |
| | <input type="checkbox"/> | HEPLISAV-B | | |
| | 1st | _____ / _____ / _____ | | |
| | 2nd | _____ / _____ / _____ | | |
| | 3rd | _____ / _____ / _____ | | |
| | | MMR¹ (2 required) | OR | MMR titer and result Required: Upload lab report |
| | 1st | _____ / _____ / _____ | | Measles titer date: _____ result: <input type="radio"/> negative |
| | 2nd | _____ / _____ / _____ | | <input type="radio"/> positive |
| | | | | Mumps titer date: _____ result: <input type="radio"/> negative |
| | | | | <input type="radio"/> positive |
| | | | | Rubella titer date: _____ result: <input type="radio"/> negative |
| | | | | <input type="radio"/> 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 initial 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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| | | | |
|---|---|-----------|---|
| | 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) Date of TB Blood Test _____/_____/_____ result: <input type="radio"/> negative <input type="radio"/> positive Required: Upload lab report |
| Placed | Step 1) 1st TB Skin Test (PPD) _____/_____/_____ | | CHEST X-RAY If IGRA is positive, enter Chest X-Ray results (within previous 12 months) below. Note: In lieu of PPD skin testing or IGRA blood testing, a normal chest x-ray (within the previous 12months) may meet the requirement. Date of Chest X-Ray ____/____/_____ result: <input type="radio"/> negative <input type="radio"/> positive Required: Upload x-ray report |
| Read | _____/_____/_____ | | |
| Induration _____ mm (record actual induration in millimeters) | | | |
| Placed | Step 2) 2nd TB Skin Test (PPD) _____/_____/_____ | | |
| Read | _____/_____/_____ | | |
| Induration _____ mm (record actual induration in millimeters) | | | |
| | Tdap (Adult dose, Tetanus, Diphtheria, Acellular Pertussis) One adult Tdap booster given within the past 10 years. | | |
| | _____/_____/_____ | | |
| | _____/_____/_____ | | |
| | Varicella (2 required) | OR | VZV IgG titer Required: Upload lab report |
| 1st | _____/_____/_____ | | VZV IgG titer date ____/____/_____ |
| 2nd | _____/_____/_____ | | result: <input type="radio"/> negative <input type="radio"/> positive |

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