UAB Student Health & Wellness Immunization Form

Non-Clinical Students

NAME: _____ DATE OF BIRTH: (mm/dd/yyyy): _____

ADDRESS: _____ PHONE: _____

PROGRAM OF STUDY: _____BLAZERID:_____@UAB.EDU

IMMUNIZATION HISTORY MUST BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER

***Copies of your original immunization records are acceptable in place of this form. Please submit completed form or immunization records directly to your UAB SH&W Patient Portal.**

FORMAT mm/dd/yyyy

1. MMR- Measles, Mumps, and Rubella: All students born in the U.S. after January 1st, 1957 must satisfy this requirement, either by two vaccine doses against each of the three diseases or laboratory evidence of immunity to all three diseases. First dose must have been received no sooner than one year after birth. *If born in the U.S. prior to January 1st, 1957, student is exempt.

EITHER

Two doses of MMR vaccine: Date: _____/_____/_____

Date: _____/_____/_____

OR

Two doses of each vaccine component:

Measles Date: _____/_____/_____ Date: _____/_____/_____

Mumps Date: _____/_____/_____ Date: _____/_____/_____

Rubella Date: _____/_____/_____ Date: _____/_____/_____

OR

Laboratory evidence of immunity to all three diseases:

Measles Date: _____/_____/_____ Positive: _____ Negative: _____

Mumps Date: _____/_____/_____ Positive: _____ Negative: _____

Rubella Date: _____/_____/_____ Positive: _____ Negative: _____

*If any laboratory titers are non-immune, 2 repeat vaccines are required. Date: _____/_____/_____ Date: _____/_____/_____

2. **Tdap**- Tetanus, Diphtheria, Acellular Pertussis: All students must have had one dose of the adult Tdap given 2006 or later. If the last adult Tdap is greater than 10 years old, a Td booster is required.

Tdap Date: _____/_____/_____

Td Date: _____/_____/_____

3. **Varicella** (chickenpox or shingles): All students born in the U.S. after January 1st, 1980 must have documentation of a positive Varicella antibody titer or two doses of Varicella vaccines given at least 28 days apart. First dose must have been received no sooner than one year after birth.*If born in the U.S. prior to January 1st, 1980, student is exempt.

EITHER

Varicella antibody titer : Positive: _____ Negative: _____ Date: _____/_____/_____

*If Varicella antibody titer is negative or equivocal, two repeat vaccinations are required.
Varicella vaccination Dose 1: _____/_____/_____ Dose 2: _____/_____/_____

OR

Varicella vaccination Dose 1: _____/_____/_____ Dose 2: _____/_____/_____

4. **Meningococcal ACWY**: All students 21 and younger are required to show documentation of a meningitis A vaccine given on/after their 16th birthday. Students age 22 and older are exempt. Date: _____/_____/_____

NAME: _____ DATE OF BIRTH: (mm/dd/yyyy): _____

5. Tuberculosis: All non-clinical students must complete a Tuberculosis screening questionnaire located in the student's SH&W Patient Portal under the Medical Clearance tab. If all answers are "no," no additional testing is required.

****All TB testing(skin tests or blood tests) MUST BE PERFORMED IN THE U.S within 3 months prior to matriculation.**

A student who has "yes" answers on the Tuberculosis Screening Questionnaire must submit:

EITHER

a. Tuberculin Skin Test (PPD) within 3 months prior to matriculation:

Date Placed: _____/_____/_____ Date Read: _____/_____/_____ Result (mm): _____ Positive: _____ Negative: _____

*If positive skin test result, IGRA required within 3 months prior to matriculation.

OR

a. IGRA (Tspot or Quantiferon TB Gold) blood test within 3 months prior to matriculation:

Date: _____/_____/_____ Positive: _____ Negative: _____

*If positive IGRA result, Chest X-Ray within 3 months prior to matriculation and UAB TB High Risk Questionnaire required.

a. Chest X-Ray Date: _____/_____/_____ Normal: _____ Abnormal: _____ (*Please attach results)

b. UAB High Risk TB Questionnaire

c. Have you been treated with anti-tubercular drugs? Yes: _____ No: _____

If yes, type of treatment: _____ Length of Treatment: _____ *Please attach supporting documentation.

Verification of the above Student Immunization Record and Tuberculosis Screening by Health Care Provider:

Verified by: _____ Title: _____

Address: _____

Phone: _____

Signature: _____ Date: _____/_____/_____