

AAMC Standardized Immunization Form

Last Name:		First Name:			Initial:	
DOB:	s	Street Address:				
Medical School:		City:				
Cell Phone:		State:				
Primary Email:		ZIP Code:				
Student ID:						
	ubella) – 2 doses of MMR vaccine or two of of immunity for Measles, Mumps and/o				flumps and (1) dose	Copy Attached
Option 1	Vaccine		Date			
MMR	MMR Dose #1					
-2 doses of MMR vaccine	MMR Dose #2			-		
Option 2	Vaccine or Test		Date			
Measles	Measles Vaccine Dose #1			s	erology Results	
-2 doses of vaccine or positive serology	Measles Vaccine Dose #2			Qualitative Titer Results:	☐ Positive ☐ Negative	
positivo deretogy	Serologic Immunity (IgG antibody t	titer)		Quantitative Titer Results:	IU/ml	
M	Mumps Vaccine Dose #1			s	erology Results	
Mumps -2 doses of vaccine or positive serology	Mumps Vaccine Dose #2			Qualitative Titer Results:	☐ Positive ☐ Negative	
positive serology	Serologic Immunity (IgG antibody t	titer)		Quantitative Titer Results:	IU/ml	
		_		S	erology Results	
Rubella -1 dose of vaccine or	Rubella Vaccine			Qualitative Titer Results:	☐ Positive ☐ Negative	
positive serology	Serologic Immunity (IgG antibody t	titer)		Quantitative Titer Results:	IU/ml	
Tetanus-diphtheria-per	tussis – One (1) dose of adult Tdap. If last	Tdap is more than	10 years old, pro	ovide dates o	flast Td and Tdap	
	Tdap Vaccine (Adacel, Boostrix, et	ic)				
	Td Vaccine (if more than 10 years since la Tdap)	ast				
Varicella (Chicken Pox)	- 2 doses of vaccine or positive serology					
	Varicella Vaccine #1			s	Serology Results	
	Varicella Vaccine #2			Qualitative Titer Results:	☐ Positive ☐ Negative	
	Serologic Immunity (IgG antibody t	titer)		Quantitative Titer Results:	IU/ml	
Influenza Vaccine - 1 do	se annually each fall					
Date of last dose			Date			
	Flu Vaccine					
COVID-19 Vaccine - prin	nary series of two (2) doses and booster	dose	Date	Comp	oany or Trade Name	
	COVID-19 Vaccine #1					
	COVID-19 Vaccine #2					
	COVID-19 Booster Bivalent Vaccir	ne				



AAMC Standardized Immunization Form

me:		Da	te of Birth:			
(La	st, First, Middle Initial)		(mm	n/dd/yyyy)		
by a QUANTITATIVE Hepatiti	Pn - 3 doses of Engerix-B, PreHevbrio, Recombivax of s B Surface Antibody test drawn 4-8 weeks after last peat another Hepatitis B vaccine series followed by a ine series, a "non-responder" status is assigned. Se	vaccine dose. A test titer repeat test titer. If the H	r ≥10mIU/mL is positive fo lepatitis B Surface Antiboo	or immunity. dy test is	Copy Attac	
mornador.	3-dose vaccines (Energix-B, PreHevbrio, Recombivax, Twinrix) or 2-dose vaccine (Heplisav-B)	3 Dose Series	2 Dose Series			
Primary Hepatitis B Series	Hepatitis B Vaccine Dose #1					
Heplisav-B only requires two	Hepatitis B Vaccine Dose #2					
doses of vaccine followed by antibody testing	Hepatitis B Vaccine Dose #3					
	QUANTITATIVE Hep B Surface Antibody Test		m i U/ml			
Repeat		3 Dose Series	2 Dose Series			
Hepatitis B Series	Hepatitis B Vaccine Dose #4					
Only If no response to primary series	Hepatitis B Vaccine Dose #5]
Heplisav-B only requires two doses of vaccine followed by	Hepatitis B Vaccine Dose #6			Ī		•
antibody testing	QUANTITATIVE Hep B Surface Antibody Test		mIU/ml			
Hepatitis B Vaccine Non-responder	If the Hepatitis B Surface Antibody test in primary and repeat vaccine series, vaccevaluated appropriately. Certain institution of non-responder status" document before	ine non-responder ons may request si	s should be counsel gning an "acknowled	ed and		
	Additional Document	ation				
include meningitis vaccine	ove additional requirements depending upon row which is mandated in some states if you live in which is mandated in some states if you live in which are also be required to provide proof of	dormitory style housir	ng. If you will be particij			
Vaccination, Test or E	xamination	Date	Result or Interp	retation		
Physical Exam (if require	ed)					
						<u> </u>
						<u> </u>
						<u> </u>
					-	<u> </u>
						<u> </u>



AAMC Standardized Immunization Form

Name:		Date of Birth:	
	(Last, First, Middle Initial)		(mm/dd/yyyy)

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 <u>regardless</u> 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)>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 S	creening Histo	ry	
	Section A		Date Placed	Date Read	Result	Interpretation
		TST #1			mm	□ Pos □ Neg □ Equiv
		TST #2			mm	☐ Pos ☐ Neg ☐ Equiv
tory	History of Negative TB Skin					
2	Test or Blood Test					
5				Date	Result	
ر د	T-spots or QuantiFERON TB Gold blood tests for tuberculosis	QuantiFERON TB (Interferon Gamma Relea			☐ Positive ☐ N	egative
5	Use additional rows as needed	QuantiFERON TB (Interferon Gamma Relea			☐ Positive ☐ N	egative
436						
a uc						
<u> </u>	Section B		Date Placed	Date Read	Result	
ב מ		Positive TST			mm	
מ				Date	Result	
- บ	History of	QuantiFERON TB (Interferon Gamma Relea			□ Positive □	Negative
y or	Positive Škin Test or	Chest X-ray*			*Provide docum	entation or result
	Positive Blood Test	Treated for latent	TB infection (LTBI)?		☐ Yes ☐ No	
ete						
mp						
e complete only one TB section based on your history		Date of Last Annua	al TB Symptom Quest	ionnaire		
asi						
Pleas						
						1



Name:

AAMC Standardized Immunization Form

Date of Birth:

(Last, First, N	nadio initialy		(mm/dd/yyyy)
	Additional In	formation	
Healthcare Professional	E SIGNED BY A LICENSED HEA		
Healthcare Professional Signature:	SIGNED BY A LICENSED HEA	LTHCARE PROFESSIO Date:	
Healthcare Professional Signature: Printed Name:	SIGNED BY A LICENSED HEA		
Healthcare Professional Signature: Printed Name: Title:	SIGNED BY A LICENSED HEA		
Healthcare Professional Signature: Printed Name: Title: Address Line 1:	SIGNED BY A LICENSED HEA		
Healthcare Professional Signature: Printed Name: Title: Address Line 1:	SIGNED BY A LICENSED HEA		
Healthcare Professional Signature: Printed Name: Title: Address Line 1: Address Line 2: City:	SIGNED BY A LICENSED HEA		
Healthcare Professional Signature: Printed Name: Title: Address Line 1: Address Line 2: City: State:	SIGNED BY A LICENSED HEA		
Healthcare Professional Signature: Printed Name: Title: Address Line 1: Address Line 2: City: State:	SIGNED BY A LICENSED HEA	Date:	
Healthcare Professional Signature: Printed Name: Title: Address Line 1: Address Line 2: City: State: Zip: Phone:	SIGNED BY A LICENSED HEA		
Healthcare Professional Signature: Printed Name: Title: Address Line 1: Address Line 2: City: State:	SIGNED BY A LICENSED HEA	Date:	

*Sources

- 1. 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
- 2. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP), MMWR, Vol 60(7):1-45
- 3. CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management, MMWR, Vol 62(RR10):1-19
- 4. Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices, MMWR Vol 67(1):1-31
- 5. 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