

AAMC Standardized Immunization Form

	Last Name:			First Name:			Middle Initial:	
	DOB:			Street Address:				
M	edical School:			City:				
	Cell Phone:			State:				
F	Primary Email:			ZIP Code:				
	Student ID:			Last 4 SS#:				
			ella) – 2 doses of MMR vaccine of for Measles, Mumps and/or Rube		easles, two (2) doses of	Mumps ar	nd (1) dose	of Rubella;
Option1 MMR			Vaccine	Date				
			MMR Dose #1					
-2	2 doses of MMR	? vaccine	MMR Dose #2		/			
Option 2			Vaccine or Test		Date	•		
		Measles	Measles Vaccine Dose #1		/			
	-2 doses of va		Measles Vaccine Dose #2		//			
	positive :	serology	Serologic Immunity (IgG, ar	ntibodies, titer)			Copy At	tached
		Mumps	Mumps Vaccine Dose #1		//			
	-2 doses of va	accine or	Mumps Vaccine Dose #2		//			
	positive :	serology	Serologic Immunity (IgG, ar	ntibodies, titer)	//		Copy At	tached
	-1 dose of va	Rubella	Rubella Vaccine	//				
	positive :		Serologic Immunity (IgG, antibodies, titer)//_				Copy At	tached
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AAMC Standardized Immunization Form

Name:		First Middle Ini	tial		_ Date of Birth: _	(mm/dd/nnn/)
	(Lasi,	, First, Middle Ini	uai)			(mm/dd/yyyy)
status.	If you have a history ent below. You only r	of a positive TST need to complete C est or IGRA resul	(PPD) <u>></u> 10mm or l DNE section. Its should not ex	GRA please supp <u>pire during prop</u> <u>or</u>		d <u>regardless</u> of prior BCG ing any evaluation and/or on dates
			Tuberculin S	creening Histor	·v	
	Section A		Date Placed	Date Read	Reading	Interpretation
		TST #1			mm	☐ Pos ☐ Neg ☐ Equiv
		TST #2			mm	☐ Pos ☐ Neg ☐ Equiv
	Negative Skin or Blood Test History	TST #3			mm	☐ Pos ☐ Neg ☐ Equiv
				Date	Result	
only	Last two skin test or IGRAs required	IGRA Blood Test (Interferon gamma releasing assay)			☐ Negative☐ Indeterminate	☐ Copy Attached
section only	Use additional rows as needed	IGRA Blood Test (Interferon gamma releasing assay)			☐ Negative☐ Indeterminate	☐ Copy Attached
		IGRA Blood Test (Interferon gamma releasing assay)		//	☐ Negative☐ Indeterminate	☐ Copy Attached
TB	Section B		Date Placed	Date Read	Reading	Interpretation
		Positive TST	//	//	mm	
ō				Date	Result	
complete one	History of Latent	Positive IGRA Blood Test			IU	☐ Copy Attached
m	Tuberculosis, Positive Skin	Chest X-ray//			☐ Copy Attached	
	Test or Positive Blood	Prophylactic Medications for latent TB taken? ☐ Yes ☐ No				
Se	Test	Total Duration of p	rophylaxis?			Months
Please		Date of Last Annua (if applicable)	al TB Symptom Que	stionnaire		☐ Copy Attached
	Section C				Date	
		Date of Diagnosis			//	
	History of Active	Date of Treatment Completed				☐ Copy Attached
	Tuberculosis	Date of Last Annual TB Symptom Questionnaire (if applicable)			//	☐ Copy Attached
		Date of Last Ches	t X-ray			☐ Copy Attached
Varice	ella (Chicken Pox) -2	doses of vaccine or	positive serology			
		.,			Date	
		Varicella Vaccine	e #1		//	_
		Varicella Vaccine				
		Serologic Immur	nity (IgG, antibodie	es, titer)		□ Copy Attached



Name: _

AAMC Standardized Immunization Form

Date of Birth:

(Last, F	First, Middle Initial)		(mm/dd/yyyy)
fluenza Vaccine1 dose	annually each fall		
	Flu Vaccine		☐ Copy Attached
	Flu Vaccine		□ Copy Attached
dditional Information:			
MUST BE COMPLETE Authorized Signature:	D BY YOUR HEALTH CARE PROVIDER O	R INSTITUTIONAL Date:/	
Printed Name:			
Title:			TTICE LISE LINIV
Address Line 1:			ffice Use Only
Address Line 2:			mee ose omy
			mice osc omy
City:			mice osc omy
City:			nice osc only
State:			nice osc only
			The Osc Only
State: Zip:	() Ext:		

^{*}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.} Updated CDC Recommendations for the Management of Hepatitis B Virus-Infected Health-Care Providers and Students, MMWR Vol 61(RR03):1-12.