

**Memorial University Medical Center  
Visiting Medical Student Record of Immunizations**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

**TB Testing(required)**

A current PPD (Mantoux), done within six months before the first day of class.

PPD Reading \_\_\_\_\_ mm Date \_\_\_\_\_,

Negative  Positive (per CDC criteria)

If current PPD is positive, or if student has a history of a positive PPD, a copy of a chest X-ray report within the last year must be attached.

**REQUIRED IMMUNIZATIONS**

**Measles/Mumps/Rubella: two immunizations or a positive titer (blood test) required for all students born after 1956.**

MMR Dose #1 M/D/Y \_\_\_\_\_ Dose #2 M/D/Y \_\_\_\_\_

**Or**  If immunizations were given separately, you must have dates (M/D/Y) for two measles, two mumps, and one rubella vaccination: Measles #1 \_\_\_\_\_, Measles #2 \_\_\_\_\_,  
Mumps #1 \_\_\_\_\_, Mumps #2 \_\_\_\_\_,  
Rubella \_\_\_\_\_.

**Or**  Positive antibody titers (IgG); copy of lab report must be attached.

Measles (Rubeola) titer: Date \_\_\_\_\_

Mumps titer: Date \_\_\_\_\_

Rubella titer: Date \_\_\_\_\_

**Chickenpox (Varicella): TITER OR VACCINATION IS REQUIRED, EVEN WITH HISTORY OF DISEASE.**

Varicella vaccine: Date of #1 \_\_\_\_\_ Date of #2 \_\_\_\_\_

**Or**  Positive Varicella titer(IgG). Copy of lab report must be attached.

**Tetanus/Diphtheria: three immunizations and a booster or a positive titer (blood test) required for all students.**

Dates of DTP primary series: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

**And** Date of last Td or Tdap(preferred) booster (must be within past 5 years) \_\_\_\_\_

**Or**  Positive Tetanus titer (IgG). Copy of lab must be attached.

Positive Diphtheria titer (IgG). Copy of lab must be attached.

**Polio: three immunizations and a booster or a positive titer (blood test) required for all students.**

Dates of series #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ Booster Date \_\_\_\_\_

**Or**  Positive Polio titer (IgG). Copy of lab must be attached.

**Hepatitis B: Full series of three is recommended prior to enrollment; the first immunization is required, and the series must be completed at the recommended intervals.**

Dates received: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

A post-vaccine titer (IgG) is required to be done 1-2 months after the third dose to demonstrate immunity. If the titer is negative, a second series is required. If the series was completed more than two months ago, the titer is not required.

Titer: Date \_\_\_\_\_ Results \_\_\_\_\_ Copy of lab must be attached.

**Information Certified by:** \_\_\_\_\_ **Date** \_\_\_\_\_

(Signature of Health Care Official)

**STAMP**