GW SMHS Immunization Form

Last Name:		**First Name:**		**Middle Initial:**	
DOB:		**Street Address:**			
Medical School:		**City:**			
Cell Phone:		**State:**			
Primary Email:		**ZIP Code:**			
GW Student ID:					

MMR (Measles, Mumps, Rubella) – *2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and (1) dose of Rubella; or serologic proof of immunity for Measles, Mumps and/or Rubella. Choose only one option.*					Copy Attached
Option 1	**Vaccine**	**Date**			
MMR *-2 doses of MMR vaccine*	MMR Dose #1				☐
	MMR Dose #2				
Option 2	**Vaccine or Test**	**Date**			
Measles *-2 doses of vaccine or positive serology*	Measles Vaccine Dose #1		**Serology Results**		☐
	Measles Vaccine Dose #2		Qualitative Titer Results:	❑ Positive ❑ Negative	
	or Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml	
Mumps *-2 doses of vaccine or positive serology*	Mumps Vaccine Dose #1		**Serology Results**		☐
	Mumps Vaccine Dose #2		Qualitative Titer Results:	❑ Positive ❑ Negative	
	or Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml	
Rubella *-1 dose of vaccine or positive serology*			**Serology Results**		☐
	Rubella Vaccine		Qualitative Titer Results:	❑ Positive ❑ Negative	
	or Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml	
Tetanus-diphtheria-pertussis – *One (1) dose of adult Tdap. If last Tdap is more than 10 years old, provide dates of last Td and Tdap*					
	Tdap Vaccine (Adacel, Boostrix, etc)				☐
	Td Vaccine *(if more than 10 years since last Tdap)*				
Varicella (Chicken Pox) - *2 doses of vaccine or positive serology*					
	Varicella Vaccine #1		**Serology Results**		☐
	Varicella Vaccine #2		Qualitative Titer Results:	❑ Positive ❑ Negative	
	or Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml	
Influenza Vaccine - *1 dose annually to be submitted each fall*					
Date of last dose		**Date**			☐
	Flu Vaccine				

Meningococcal Vaccine - *A,C,Y,W 135* given on or after their 16th birthday, OR signed waiver request Form*

Date of last dose		**Date**		☐
	If submitting a waiver please submit as an attachment			

GW SMHS Immunization Form

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

					Copy Attached
Hepatitis B Vaccination - *3 doses of Engerix-B, PreHevbrio, Recombivax HB or Twinrix vaccines or 2 doses of Heplisav-B vaccine followed by a **QUANTITATIVE** Hepatitis B Surface Antibody test drawn 4-8 weeks after last vaccine dose. A test titer ≥10mIU/mL is positive for immunity. If the test result is negative, CDC guidance recommends that HCP receive one or more additional doses of Hepatitis B vaccine up to completion of a second series, followed by a repeat titer test 4-8 weeks after the last vaccine dose. If a single additional vaccine dose does not elicit a positive test result, administer additional vaccine doses to complete the second series using the schedule approved for the primary series of a given product. If the Hepatitis B Surface Antibody test is negative (<10 mIU/mL) after receipt of 2 complete vaccine series, a "non-responder" status is assigned. See: http://dx.doi.org/10.15585/mmwr.rr6701a1 for additional information.*					
Primary Hepatitis B Series Heplisav-B only requires two doses of vaccine followed by antibody testing	3-dose vaccines (Energix-B, PreHevbrio, Recombivax HB, Twinrix) or 2-dose vaccine (Heplisav-B)	**3 Dose Series**	**2 Dose Series**		☐
	Hepatitis B Vaccine Dose #1				
	Hepatitis B Vaccine Dose #2				
	Hepatitis B Vaccine Dose #3				
	and **QUANTITATIVE** Hep B Surface Antibody Test		_____ mIU/ml		
Additional doses of Hepatitis B Vaccine *Only if initial quantitative titer is <10 mIU/ml to* Heplisav-B only requires two doses of vaccine followed by antibody testing		**3 Dose Series**	**2 Dose Series**		☐
	Hepatitis B Vaccine Dose #4				
	Hepatitis B Vaccine Dose #5				
	Hepatitis B Vaccine Dose #6				
	and **QUANTITATIVE** Hep B Surface Antibody Test		_____ mIU/ml		
Hepatitis B Vaccine Non-responder	If the Hepatitis B Surface Antibody test is negative (titer less than 10 mIU/mL) after a primary and repeat vaccine series, vaccine non-responders should be counseled and evaluated appropriately. Certain institutions may request signing an "acknowledgement of non-responder status" document before clinical placements.				
Additional Documentation					
Some institutions *may have additional requirements depending upon rotation, school requirements or state law. Examples include meningitis vaccine which is mandated in some states if you live in dormitory style housing. If you will be participating in an international experience, you may also be required to provide proof of vaccines such as yellow fever or typhoid.*					

Vaccination, Test or Examination	**Date**	**Result or Interpretation**	
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

GW SMHS 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. Two kinds of tests are used to determine if a person has been infected with TB bacteria: the TB skin test (TST) and the TB blood test (IGRA). GW SMHS requires one IGRA blood test **regardless** of prior BCG status. If you have a history of a positive IGR blood test, please supply information regarding any evaluation and/or treatment below.*

Tuberculosis Screening History

Please complete only one TB section based on your history

Section A

History of Negative TB Blood Test

(Either QuantiFeron TB Gold or T-Spot)

Use additional rows as needed

	Date	Result
QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)		❑ Positive ❑ Negative ❑ Indeterminate
QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)		❑ Positive ❑ Negative ❑ Indeterminate

Section B

History of Positive Blood Test

(Either QuantiFeron TB Gold or T-Spot)

	Date	Result
QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)		❑ Positive ❑ Negative ❑ Indeterminate
Chest X-ray*		*Provide documentation or result
Treated for **latent** TB infection (LTBI)?		❑ Yes ❑ No
Date of Last Annual TB Symptom Questionnaire		

GW SMHS Immunization Form

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

Additional Information

MUST BE SIGNED BY A LICENSED HEALTHCARE PROFESSIONAL OR DESIGNEE:

Healthcare Professional Signature:		**Date:**
Printed Name:		Office Use Only
Title:		
Address Line 1:		
Address Line 2:		
City:		
State:		
Zip:		
Phone:	(____) _____-_____ **Ext:** _____	
Fax:	(____) _____-_____	
Email Contact:		