



# University of Cincinnati Standardized Immunization Form

## Health Professions Student Requirements

College of Medicine (MD), College of Pharmacy, College of Nursing, Advanced Medical Imaging (AMIT), Athletic Training, Audiology, Communication Sciences Disorders, Health Informatics, Medical Laboratory Science, Nutrition and Dietetics, Occupational Therapy, Physical Therapy, Respiratory Therapy, Speech Language Pathology, Social Work

First Name		Last Name	
M#		DOB	
UC Email		Phone #	

### REQUIRED IMMUNIZATIONS

**Hepatitis B** - 3 doses of *Engerix-B, PreHevbrio, Recombivax* or *Twinrix* vaccines or 2 doses of *Heplisav-B* vaccine followed by a **QUANTITATIVE** Hepatitis B Surface Antibody test drawn more than 4 weeks after last vaccine dose. A test titer >10mIU/mL is positive for immunity. If the test result is negative, repeat another Hepatitis B vaccine series followed by a repeat test titer. If the Hepatitis B Surface Antibody test is negative after the repeat vaccine series, a "non-responder" status is assigned.

Primary Series	Vaccine	Date	
		3 Dose Series	2 Dose Series
<b>Primary Hepatitis B Series AND Quantitative Titer</b>  3-dose vaccine ( <i>Energix-B, PreHevbrio, Recombivax, Twinrix</i> ) or 2-dose vaccine ( <i>Heplisav-B</i> )	Hepatitis B Vaccine Dose #1		
	Hepatitis B Vaccine Dose #2		
	Hepatitis B Vaccine Dose #3		
	<b>QUANTITATIVE</b> Hep B Surface Antibody Test		_____mIU/ml
Repeat Series	Vaccine	Date	
<b>Repeat Hepatitis B Series AND Quantitative Titer</b>  <i>Only if no response to primary series</i>  3-dose vaccine ( <i>Energix-B, PreHevbrio, Recombivax, Twinrix</i> ) or 2-dose vaccine ( <i>Heplisav-B</i> )	Hepatitis B Vaccine Dose #4		
	Hepatitis B Vaccine Dose #5		
	Hepatitis B Vaccine Dose #6		
	<b>QUANTITATIVE</b> Hep B Surface Antibody Test		_____mIU/ml
<b>Hepatitis B Vaccine Non-responder</b>	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 "acknowledgment of non-responder status" document before clinical placements.		

**Tuberculosis (TB) Screening** – Results of two-step (2) TB Skin Tests (TSTs) or (1) IGRA blood test done within the past 3 months. Thereafter, students will need annual TB exposure and symptoms screening with subsequent TB testing if indicated. History of previous positive TB skin testing (≥ 10 mm induration) or (+) TB blood test must be accompanied by documentation of the evaluation and/or treatment of this condition. You only need to complete ONE section, A or B.

Section A	Date Placed	Date Read	Result	Interpretation
<b>No History of Abnormal TB Skin Test or Blood Test</b> TST or T-spot/QuantiFERON TB Gold blood tests for tuberculosis	TST #1		_____mm	<input type="checkbox"/> Negative
	TST #2		_____mm	<input type="checkbox"/> Negative
	QuantiFERON TB Gold or T-Spot			<input type="checkbox"/> Negative
Section B	Date Placed	Date Read	Result	
<b>History of Positive Skin Test or Positive/Indeterminate Blood Test</b> TST or T-spot/QuantiFERON TB Gold blood tests for tuberculosis	Positive TST		_____mm	
	QuantiFERON TB Gold or T-Spot			<input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate
	Chest x-ray*			*Provide documentation or result
	Treated for latent TB infection (LTBI)?*			<input type="checkbox"/> Yes <input type="checkbox"/> No *Provide documentation
	Date of Last Annual TB Symptom Questionnaire			



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### REQUIRED IMMUNIZATIONS (continued)

**MMR (Measles, Mumps, Rubella)** – 2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and (2) doses of Rubella; or serologic proof of immunity for Measles, Mumps and/or Rubella. Choose only one option.

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			
	Serologic Immunity (IgG antibody titer)			
Mumps - 2 doses of vaccine or positive serology	Mumps Vaccine Dose #1		Serology Results	
	Mumps Vaccine Dose #2			
	Serologic Immunity (IgG antibody titer)			
Rubella - 2 doses of vaccine or positive serology	Rubella Vaccine Dose #1		Serology Results	
	Rubella Vaccine Dose #2			
	Serologic Immunity (IgG antibody titer)			
<b>Tetanus-diphtheria-pertussis</b> – One (1) dose of adult Tdap within the past 10 years.		<b>Date</b>		
	Tdap Vaccine (Adacel, Boostrix, etc)			
<b>Varicella (Chicken Pox)</b> - 2 doses of vaccine or positive serology		<b>Date</b>		
	Varicella Vaccine Dose #1		Serology Results	
	Varicella Vaccine Dose #2			
	Serologic Immunity (IgG antibody titer)			
<b>Influenza</b> – one dose annually each fall		<b>Date</b>		
	Influenza Vaccine (Fluzone, Flublok)			
<b>Meningococcal conjugate (ACWY)</b> - one dose given on or after 16th birthday if student will be younger than 22 years of age at the start of their first semester with UC		<b>Date</b>		
	Meningococcal conjugate (ACWY) Vaccine			

### THIRD PARTY REQUIREMENTS

Certain programs at the University have clinical and/or external placements that are a requirement for program completion. To the extent permitted by law, Students enrolled in such programs will be expected to comply with all rules, policies, guidelines, and requirements of any third party placement, including but not limited to vaccination and background check requirements. Any student's failure to comply with such third-party rules, policies, guidelines or requirements may result in the student not being able to complete and graduate from their program.

Coronavirus (Covid-19) - primary series of two monovalent doses OR one bivalent	Date	Manufacturer
Covid-19 Vaccine Dose #1		
Covid-19 Vaccine Dose #2		
Covid-19 Bivalent Vaccine		



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### RECOMMENDED IMMUNIZATIONS

<b>Serogroup B meningococcal (MenB) vaccine - 2 doses of vaccine</b>		<b>Date</b>	
Select vaccine type: <input type="checkbox"/> Trumenba <input type="checkbox"/> Bexsero	MenB Vaccine Dose #1		
	MenB Vaccine Dose #2		
<b>Hepatitis A - 2 doses of vaccine</b>		<b>Date</b>	
	Hep A Vaccine Dose #1		
	Hep A Vaccine Dose #2		
<b>Polio - 4 doses of vaccine</b>		<b>Date</b>	
	Polio Vaccine Dose #1		
	Polio Vaccine Dose #2		
	Polio Vaccine Dose #3		
	Polio Vaccine Dose #4		
<b>Human papilloma virus (HPV) - 3 doses of vaccine, or 2 doses if series started prior to age 15</b>		<b>Date</b>	
	HPV Vaccine Dose #1		
	HPV Vaccine Dose #2		
	HPV Vaccine Dose #3		

### MUST BE SIGNED BY A LICENSED HEALTHCARE PROFESSIONAL OR DESIGNEE:

<b>Healthcare Professional Signature</b>		<b>Date</b>
<b>Printed Name</b>		Office Use Only
<b>NPI #</b>		
<b>Title</b>		
<b>Street Address</b>		
<b>City, State, Zip Code</b>		
<b>Phone Number</b>	(____) _____ - _____ Ext. _____	
<b>Fax Number</b>	(____) _____ - _____	
<b>Email Contact</b>		