UNIVERSITY OF MICHIGAN MEDICAL SCHOOL
RECORD OF REQUIRED IMMUNIZATIONS

PART I - TO BE COMPLETED BY THE STUDENT

Name:_____
Last First MI

Date of Birth:_____ SSN: _____

Street Address: _____

City: _____State: _____Zip: _____

Phone: (___)_____ Today's Date: _____

PART II - TO BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN

A. Hepatitis B Vaccination

1. ..... Month/Year _____
2. ..... Month/Year _____
3. ..... Month/Year _____
4. Immune Titer. (Required) Result ..... Month/Year _____

B. Measles, Mumps, and Rubella

1. 2 Doses of MMR Vaccine ..... Month/Year _____
   ..... Month/Year _____
2. Born before 1957; immunization for Mumps & Measles not required...(DOB) Month/Year _____
3. Immune titer. (Optional) Result ..... Month/Year _____

C. Tuberculosis

1. PPD skin test dated April 1, 2009 or later **(Tine test unacceptable)**
   Give date and test results Month/Year _____
   ....Result ___ pos ___ neg
2. If PPD Positive – Chest x-ray done after the skin test conversion or within one year.
   Give date and result of chest x-ray Month/Year _____
   ....Result ___ pos ___ neg
3. If PPD positive, symptom review for active TB required.

D. Chicken Pox (Varicella)

1. Documented case of h-zoster? ..... Yes No (circle one)
2. Two doses of Varicella Vaccine? ……Month/Year _____//_____
3. Immune titer: (Optional) Result……Month/Year _____//_____

E. Tetanus/Pertussis

1. Most recent Tetanus booster? ..... Month/Year _____
2. One-time booster for Tdap? ..... Month/Year _____

HEALTH CARE PROVIDER

Name:_____Address: _____
(printed)

_____

Signature:_____Phone: _____

REVIEWER'S COMMENTS:

_____

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