UNIVERSITY OF THE INCARNATE WORD
SCHOOL of OSTEOPATHIC MEDICINE

University of Incarnate Word
School of Osteopathic Medicine

SENTRY MD

PART IV STUDENT IMMUNIZATION RECORD | *Please have the following form completed, signed and stamped your healthcare provider OR LEAVE BLANK and submit all requirements listed below on the original forms from the clinic or provider you received them at.*

Last Name:	**First Name:**	**Date of Birth:**

Measles, Mumps and Rubella (MMR): Positive QUANTITATIVE IgG antibody titers are required for Mumps, Measles and Rubella. If a titer results in non-immunity a two-vaccine series and follow-up titer must be completed. *Titers must include numerical result and or numerical reference ranges.

MMR Titer Dates:	MMR 2 Vaccine Series (Optional):	**If Non-immune titer- two-vaccine Series after titer:**
Measles Titer: __/__/____ **Result: ☐Immune ☐ Non-Immune** **Mumps Titer:** __/__/____ **Result: ☐Immune ☐ Non-Immune** **Rubella Titer:** __/__/____ **Result: ☐Immune ☐ Non-Immune** **☐ Attach copy of quantitative titer report**	1). __/__/____ 2). __/__/____	1). __/__/____ 2). __/__/____ ***Submit repeat Quantitative Titer report from the lab 6 weeks after booster.**

Varicella (Chicken Pox): Positive QUANTITATIVE IgG antibody titer is required. If a titer results in non-immunity a two-vaccine series and follow-up titer must be completed. *Titers must include numerical result and or numerical reference ranges.

Varicella Titer Date: __/__/____ **Result: ☐Immune ☐ Non-Immune** **☐ Attach copy of quantitative titer report**	Varicella 2 Vaccine Series (Optional): 1). __/__/____ 2). __/__/____	**If Non-immune titer- two-vaccine Series after titer:** 1).__/__/____2).__/__/____ ***Submit repeat Quantitative Titer report from the lab 6 weeks after 2 doses.**

Hepatitis B: Positive QUANTITATIVE IgG antibody titer is required *If a titer results in non-immunity an additional three vaccine series or Heplisav-B two dose series and follow-up titer must be completed. *Titers must include numerical result and or numerical reference ranges.

HepB Titer Date: __/__/____ **Result: ☐Immune ☐ Non-Immune** **☐ Attach copy of quantitative titer report**	HepB Vaccine Series (Optional): 1). __/__/____ 2). __/__/____ 3). __/__/____ Heplisav- B Vaccine Series (Optional): 1). __/__/____ 2). __/__/____	**If non-immune titer -Repeat full vaccine Series:** 1). __/__/____ 2). __/__/____ 3). __/__/____ ☐ Energix-B ☐ Heplisav-B ***Submit repeat Quantitative Titer report from the lab 6 weeks after final dose in new series is completed.**

Influenza Vaccine (Flu): Required seasonally, typically by September 30th each year. Declinations are NOT accepted.

Flu Vaccine Date: __/__/____

Tetanus Diphtheria, Pertussis (Tdap): Tdap vaccine within the past ten years is required. TD booster is accepted ONLY IF TDAP ON FILE.

Tdap Vaccine Date: __/__/____ Lot #____ Exp_____	TD Booster (*Tdap must be documented*): __/__/____

Meningococcal (Meningitis): Vaccine must be within past five years for anyone 22 or younger.

Meningococcal Vaccine Date: __/___/___

Poliomyelitis (Polio): Primary vaccine series dates (IPV or OPV) **OR** one booster date is accepted if dated after 1988.

IPV or OPV: 1). __/__/____ 2). __/__/____ 3). __/__/____**OR Polio Booster After 1988:** __/___/___**OR Polio Titer:** __/__/____
Result: ☐Immune ☐ Non-Immune

Tuberculosis Skin Test (PPD/Mantoux): A negative PPD skin test within 12 months OR negative TB Blood test (QuantiFERON or T-spot) within 12 months of the 1st day of class. **Annual update required.**
*If POSITIVE: a Chest X-ray with NEGATIVE results is required. Students with a POSITIVE TB test and NEGATIVE Chest X-ray will also be counseled regarding latent TB and required to comply with Direct Observational Therapy according to CDC guidelines.

TB Skin Plant Date: __/___/___ TB Skin Read Date: __/___/___ **Result: ____mm ☐ Neg ☐ Pos OR** **QuantiFERON TB Gold Date: ___/___/__☐ Neg ☐ Pos OR** **T-Spot Date: ___/___/__☐ Neg ☐ Pos**	**IF positive TB; Chest X-Ray Date:** __/__/____ **Result: ____mm ☐ Neg ☐ Pos**

Primary Care Provider Signature AND Provider's stamp is required for immunizations on this form to be accepted.

PLACE PROVIDER'S STAMP HERE

_____

Provider's Signature *Date*

Provider Name (printed): _____

Phone Number: (____) _____