UCCOM VISITING STUDENT IMMUNIZATION RECORD

Name of Applicant _____ DOB _____ SS#_____

The UCCOM requires that all students participating in clinical rotations show proof of testing for tuberculosis and of immunity to measles, mumps, rubella, varicella, tetanus/diphtheria/pertussis, hepatitis B and influenza. Applicants must be free from infectious diseases at the start of the elective. Any student who becomes ill with a communicable disease during participation as a visiting student is **REQUIRED** to notify the course director/attending physician, and remove himself/herself from patient care activity. All students must report any absences to the Registrar. ***This University of Cincinnati Visiting Student Immunization Form must be completed and signed by a health official at your school and submitted with elective application.***

CERTIFICATION BY PHYSICIAN, NURSE OR SCHOOL OFFICIAL

Please check the following immunizations that have been completed by the above named student.

_____ TB SKIN TEST (Mantoux): Past two annual test dates required or 2-step testing, most recent test **MUST** be within 12 months of rotation start date.
Date Placed : ___/____/____ Date Read: ___/___/___Results____mm NEG/POS
Date Placed : ___/____/____ Date Read: ___/___/___Results____mm NEG/POS
If above test positive, a Chest X-ray or Quantiferon within the last 12-months is required.

_____ Tetanus/Diphtheria/Pertussis: Primary series plus Tdap booster within the last 10 years.
Tdap Booster – Date: ____/____/____

_____ MMR (measles, mumps, rubella): 2 Vaccines or Positive Serology
Measles Vaccine Dates:___/___/___ and___/___/___or titer date___/___/___ NEG/POS
Mumps Vaccine Dates: ___/___/___and___/___/___or titer date ___/___/___NEG/POS
Rubella Vaccine Dates: ___/___/___and___/___/___or titer date ___/___/___NEG/POS

_____ Hepatitis B: Series of 3 doses and Positive Serology
Dates: (1) ____/____/____ (2) ____/____/____ (3) ____/____/____
HBSAB Titer Date: _____Result_____

_____ Varicella: 2 doses of vaccine at least 4 weeks apart or serologic evidence of immunity.
Varicella antibody titer: _____Date: ____/____/____Result_____
Varicella vaccine: 1st dose ____/____/____
2nd dose____/____/____

_____ Annual Flu vaccine Date_____

Student signature: _____ Date: _____

M.D., R.N., or School Official (Signature): _____ Date: _____

Name _____ Title _____
Address _____ Phone _____
_____