

Mandatory Immunization Health History Form

◆HEALTH PROFESSIONS◆



Section A: Required Immunizations Information

Please note: All titers must include a lab report

1. MMR / MEASLES, MUMPS, RUBELLA VACCINE:

Required for everyone born after Dec. 31, 1956. Two doses are required. You must have received on or after 12 months of age AND in 1971 or later. The second dose must have been received at least 30 days after the first dose. OR Provide lab evidence of immunity by doing a blood test to check for antibodies for Measles, Mumps and Rubella. If you do a blood test, you need to provide the results on a lab form that should be faxed or mailed with the completed Mandatory Immunization Health History Form.

2. HEPATITIS B VACCINE:

Students are required to receive this vaccination. Three dose series are required. You must get the first dose prior to start of classes.

3. MCV4 (MENACTRA/MENVEO) / MENINGOCOCCAL MENINGITIS VACCINE:

The Advisory Committee on Immunization Practices (ACIP) currently recommends this vaccine for freshmen planning to live in campus dormitories/residence halls. Students are required to receive this vaccination **OR** read the CDC's Vaccine Information Statement and sign where indicated on the Form to decline. Read the VIS here: <https://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.html>. Signing the waiver indicates you understand the possible risk in not receiving this vaccine.

4. TD or/and TDAP VACCINE:

Td (Tetanus/Diphtheria) or/and Tdap (Tetanus/Diphtheria/Pertussis):Tdap = Adacel/Boostrix. Booster shot within last 10 years. May have TD but must have at least one instance of Pertussis.

5. VARICELLA (CHICKENPOX):

Provide proof of two doses of Varivax **OR** provide results of a blood test on a lab form verifying immunity to Chickenpox/Varicella. **Please note that all titers must include the lab report.**

6. TUBERCULOSIS SCREENING:

Required for All Students. Refer to the grid below to determine appropriate timeframe for TB Screening and type of testing required. If either screening is returned positive, then you must get a chest x-ray and submit a copy of the report.

- **FOR TST (Mantoux):** The result of the TST needs to be recorded in mm in the space provided on the form and whether considered negative or positive.
- **For Interferon-based Assay, IGRA, (QFT or Tspot):** You must submit a copy of the lab report.

COLLEGE	PRIOR TO CLASS START	ACCEPTED TEST TYPE(S)
Dental	Within 12 months	TST (must complete 2-step) or IGRA
Medicine	Within 12 months	TST or IGRA
PA	Within 12 months	TST (must complete 2-step) or IGRA
Nursing	Within 12 months	TST or IGRA
Pharmacy	Within 12 months	TST or IGRA
PHHP	Within 2 months	TST or IGRA

Basic Instructions:

- DO NOT WAIT!** Submit documents prior to orientation or registration. Late, incomplete or inaccurate information will prevent course registration.
- Include UFID on all correspondence. Print all student information legibly (name, phone, etc.).
- Keep a copy for your records.
- Check UF account to see if the immunization checklist has been cleared: one.uf.edu.** Health Compliance does not send confirmation that an individual form has been received.

How to Submit:

- ****EMAIL:**
healthcompliance@shcc.ufl.edu
- **FAX:**
(352) 392-0938
Please do not include a cover sheet or other pages that are not required.
- **MAIL:**
UF Student Health Care Center,
Health Compliance Office
P.O. Box 117500,
Gainesville, FL 32611-7500

****Please note:** Email sent over the Internet is not necessarily secure. Please be aware that the University of Florida (UF) Health Compliance Office and the UF Student Health Care Center (SHCC) cannot guarantee the confidentiality or security of any information sent over the Internet when using email. UF and/or the SHCC shall not be liable for any breach of confidentiality resulting from such use of email via the Internet.

OFFICE USE ONLY

MRN: _____



**Health Professions
Immunization Form**

REQUIRED – UFID NUMBER (8 digits):

□	□	□	□	-	□	□	□	□
---	---	---	---	---	---	---	---	---

Name: _____ Date of Birth: _____ Phone: _____

Health Profession (*check one*):

- Dental
 Medicine/PA
 Nursing
 Pharmacy
 PHHP

Vaccine Name	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Titer Date & Result (Must include lab report)
1. MMR (Measles, Mumps, Rubella) (2 doses on or after 12 months of age)			--NOT APPLICABLE--	
2. Hepatitis B				
3. MCV4 (Menactra/Menveo)			--NOT APPLICABLE--	--NOT APPLICABLE--

I have read the information about MCV4 (Menactra/Menveo) / Meningococcal Meningitis and decline receipt of this vaccine.

Student Signature _____

Date _____

4. Td or Tdap (Adacel/Boostrix) (Must have one instance of pertussis)			--NOT APPLICABLE--	--NOT APPLICABLE--
5. Varicella (Varivax)			--NOT APPLICABLE--	

6. Tuberculosis Screening: (see instructions on p.1)

TB Skin Test by TST (Mantoux)	#1	Date Placed	Date Read	MM	Result: Neg Pos
	#2	Date Placed	Date Read	MM	Result: Neg Pos
OR Interferon-based Assay (QFT or Tspot)	Date	Result	Submit copy of lab report		
Chest X-ray (Only if positive TST or Lab Test)	Date	Result	Submit copy of x-ray report		

Important! Make a copy of this page and all lab reports to keep for your records.

An official stamp from a doctor's office, clinic or health department AND an authorized signature must appear here or this form will not be approved.

Official Office Stamp Here

Physician or Authorized Signature

Date