

UCSF Student Health Service - Immunization Form 2002

Last Name _____	First Name _____	Middle Initial _____	Date of Birth _____	Gender _____
Social Security Number _____	School/Program _____	E-mail _____	Phone _____	

TB Skin Testing

TB skin test <u>within 3 months prior to entering school</u> OR Prior positive skin test (BCG alone not acceptable) Date: ____/____/____ mm reading _____	Positive skin test - chest x-ray report required (not greater than 3 months old unless INH therapy completed) Date: ____/____/____ x-ray results: <input type="checkbox"/> normal <input type="checkbox"/> abnormal	INH therapy taken? <input type="checkbox"/> yes Date: ____/____/____ Length of tx _____ months <input type="checkbox"/> no Schedule appt when school starts
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Measles (rubeola)	Mumps
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2 doses live measles vaccine or 2 MMR vaccine OR Positive measles titer Date: ____/____/____ Dose 1: <input type="checkbox"/> Measles or <input type="checkbox"/> MMR ? Date: ____/____/____ Dose 2: <input type="checkbox"/> Measles or <input type="checkbox"/> MMR ?	1 dose live mumps vaccine or MMR vaccine OR Positive mumps titer Date: ____/____/____ Dose 1: <input type="checkbox"/> Mumps or <input type="checkbox"/> MMR ?
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Rubella (German measles)	Varicella (Chickenpox)
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1 dose live rubella vaccine or MMR vaccine OR Positive rubella titer Date: ____/____/____ Dose 1: <input type="checkbox"/> Rubella or <input type="checkbox"/> MMR ?	2 doses live varicella vaccine OR Positive varicella titer Date: ____/____/____ Dose 1: _____ Date: ____/____/____ Dose 2: _____ ** Hx of disease is NOT sufficient
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Hepatitis B

Students are **REQUIRED** to have 2 of the 3 doses in the Hepatitis B series before entering school.

3 doses hepatitis B vaccine OR Positive hepatitis B surface Ab titer Date: ____/____/____ Dose 1: _____ Date: ____/____/____ Dose 2: _____ Date: ____/____/____ Dose 3: _____	Previous infection - Need core antibody & surface antigen titers Date: ____/____/____ Hep B core Ab titer Date: ____/____/____ Hep B surface antigen
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Directions: 1) Complete this form 2) Mail to: Student Health, 500 Parnassus Ave, MU-H005, San Francisco, CA 94143-0722

I attest that all dates and immunizations listed above are correct and accurate.

Provider's Signature _____
 Physician, Nurse Practitioner or Physician's Assistant

Provider's name printed _____ Phone number _____
 Physician, Nurse Practitioner or Physician's Assistant