

## Immunization & TB Screening

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First MI  
Phone Number: ( ) \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_  
Intend to live on campus? Yes  No  Entering Dominican? \_\_\_\_/\_\_\_\_/\_\_\_\_  
Semester/Year

***The following to be completed by Health Care Provider:***

**Immunizations required of all** students entering Dominican University of California:

- MMR – Measles, Mumps, Rubella** (two doses if born after 1/1975)  
Dates of vaccinations: 1) \_\_\_\_\_ 2) \_\_\_\_\_  
OR documentation of laboratory immunity with dates:  
Measles IgG antibody : date \_\_\_\_\_  immune  non-immune  
Mumps IgG antibody : date \_\_\_\_\_  immune  non-immune  
Rubella IgG antibody : date \_\_\_\_\_  immune  non-immune
- Tuberculosis Screening** – Must be completed within 3 months prior to entering Dominican  
Date of PPD given/read: \_\_\_\_\_ Result: \_\_\_\_\_ mm induration  
Interpretation: \_\_\_\_\_  
 *Reactors only;* Date of last chest x-ray: \_\_\_\_\_ Result: \_\_\_normal\_\_\_abnormal  
Date of last symptom checklist \_\_\_\_\_ Result: \_\_\_normal\_\_\_abnormal
- Meningococcal Vaccine** – Date of vaccination: \_\_\_\_\_ (dorm residents)

**Immunizations recommended for** students entering Dominican University (these may be required for health science students prior to starting clinical rotations):

- Tetanus:** Date of last Tetanus \_\_\_\_\_  Tdap (preferred)  Td
- Varicella** (chicken pox) Dates of 2 doses: (1) \_\_\_\_\_ (2) \_\_\_\_\_  
OR Varicella IgG antibody : date \_\_\_\_\_  immune  non-immune
- Hepatitis B:** Dates given: (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_  
If it has been 5 years or more since the last dose was administered, a Hepatitis B antibody blood test should be done to verify current immunity.  
Date of Hep B S Ab IgG: \_\_\_\_\_ Result: \_\_\_Immune\_\_\_ Non-immune
- HPV** Dates of 3 doses: (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_ (women only <26)
- Hepatitis A:** Dates of 2 doses: (1) \_\_\_\_\_ (2) \_\_\_\_\_ (travelers, healthcare wrks)

**Health Care Provider:** \_\_\_\_\_  
(Print Name)

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_