DOMINICAN UNIVERSITY of CALIFORNIA 1890

Your Healthcare Provider must complete the following: TB Screening & Immunizations

Patient Name: _____ **Birthdate:** _____/_____/_____
First Last MI

Living on campus: ☐ **Yes** * ☐ **No**

THE FOLLOWING TO BE COMPLETED BY HEALTH CARE PROVIDER

Immunizations required of all students entering Dominican University of California.

❖ **Tuberculosis Screening –** Must be administered within the last 12 months.

Date PPD given: _____ read: _____ Result: _____ mm induration › ☐ Neg ☐ Pos

- If PPD positive › Quantiferon Test Results: ☐ Pos ☐ Neg Date: _____
- If blood test positive, date of CXR _____ Result: ☐ Normal ☐ Abnormal
- Prophylactic treatment taken: □ yes □ no Duration of Tx: _____ months
- If not treated, please explain:

❖ **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

❖ **Tdap - Tetanus/Diphtheria/Pertussis –** recent w/in 9 years

- Date: _____ (must contain Pertussis)

❖ **Meningococcal Vaccine –** Required for residents

- Date of vaccination: _____, if over 5 years a booster is required.
- Date of booster: _____

❖ **Varicella (**chicken pox) **–** Required for residents; Hx of disease must be verified by blood test indicating immunity.

- Dates of 2 doses: 1) _____ 2) _____ OR
- Varicella IgG antibody date: _____ □ immune □ non-immune

Health Care Provider: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____