



SCHOOL OF MEDICINE IMMUNIZATION COMPLIANCE FORM

Louisiana R.S. 17:170 – Schools of Higher Learning

Tulane University Campus Health, Health Center – Downtown 504-988-6929, Uptown 504-865-5255
Upload this form and any lab reports in the Patient Portal: campushealth.tulane.edu/immunizations.

How to Submit

- 1) Make sure your health provider completes and signs the **AAMC Standardized Immunization Form** (included in this packet) and provides copies of applicable lab reports. All lab reports must indicate your name and date of birth. **NOTE: Physical Exam and Respiratory Fit Testing are NOT REQUIRED for entering students.**
- 2) Tuberculosis screening (Skin or blood test) should be done within a year prior to start date.
- 3) T-spot IGRA Tuberculosis blood tests are only accepted if performed in the US.
- 4) All lab reports (for titers, IGRAs, etc.) must be uploaded onto the Patient Portal, and all lab reports must be in English.
- 5) Visit our website at campushealth.tulane.edu/immunizations.
- 6) **Log on to the Patient Portal** using your Tulane log-on information (your email address without the @tulane.edu and your email password).
It may take up to three business days after you receive your Tulane email account before you can access the Patient Portal. If you still cannot log in to the Patient Portal after three days, please contact the immunization office for assistance at immunizations@tulane.edu.
- 7) **Choose Immunizations and Enter Dates.** Fill in all the dates and information copied directly from your form. When finished, click “Submit”. Please **scan your immunization documents**.
NOTE: Your files can be no larger than 4MB. (Scan in black and white or at a setting of 150 DPI to achieve a smaller file).
- 8) Next, use the **Upload Documents** link to upload your scanned copy of the completed form along with any necessary lab reports.
- 9) Once your form is uploaded, it may take up to five business days for the form to be reviewed and verified. Check your Tulane email regularly for notification of secure messages from the Health Center.
- 10) **You will receive a secure message** via the Patient Portal notifying you whether your records are either
(✓) in compliance which allows you to register for classes or
(✗) out of compliance which means you cannot register for classes until you upload the additional records specified via secure message.
- 11) All communication regarding your immunization records is private and visible only via the Patient Portal. You will receive a secure message notification in your Tulane email directing you to the Patient Portal. You should **submit health information only via the Patient Portal** and never by email.
- 12) You will be eligible to register for classes **only** once your immunization records are in compliance with University policy and Louisiana law.

Please provide records of childhood vaccines and any vaccines received prior to international travel. NOTE: ALL immunizations are required unless medically contraindicated. Medical Exemptions are allowed with written documentation from a physician.

For assistance, please email
immunizations@tulane.edu.



AAMC Standardized Immunization Form

Last Name:	First Name:	Middle Initial:
DOB:	Street Address:	
Medical School:	City:	
Cell Phone:	State:	
Primary Email:	ZIP Code:	
Student ID:		

MMR (Measles, Mumps, Rubella) – 2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and (1) dose of Rubella; or serologic proof of immunity for Measles, Mumps and/or Rubella. Choose only one option.				Copy Attached
Option 1	Vaccine	Date		
MMR <i>-2 doses of MMR vaccine</i>	MMR Dose #1			
	MMR Dose #2			
Option 2	Vaccine or Test	Date		
Measles <i>-2 doses of vaccine or positive serology</i>	Measles Vaccine Dose #1		Serology Results	
	Measles Vaccine Dose #2		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Serologic Immunity (IgG, antibodies, titer)		Quantitative Titer Results:	_____ IU/ml
Mumps <i>-2 doses of vaccine or positive serology</i>	Mumps Vaccine Dose #1		Serology Results	
	Mumps Vaccine Dose #2		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Serologic Immunity (IgG, antibodies, titer)		Quantitative Titer Results:	_____ IU/ml
Rubella <i>-1 dose of vaccine or positive serology</i>			Serology Results	
	Rubella Vaccine		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Serologic Immunity (IgG, antibodies, titer)		Quantitative Titer Results:	_____ IU/ml
Tetanus-diphtheria-pertussis – One (1) dose of adult Tdap. If last Tdap is more than 10 years old, provide date of last Td and Tdap				
	Tdap Vaccine (Adacel, Boostrix, etc)			
	Td Vaccine (if more than 10 years since last Tdap)			
Varicella (Chicken Pox) -2 doses of vaccine or positive serology				
	Varicella Vaccine #1		Serology Results	
	Varicella Vaccine #2		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
			Quantitative Titer Results:	_____ IU/ml
Influenza Vaccine --1 dose annually each fall				
<i>Second flu vaccine is for updating your form only</i>		Date		
	Flu Vaccine			
	Flu Vaccine			



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Hepatitis B Vaccination --3 doses of <i>Energix-B, Recombivax</i> or <i>Twinrix</i> or 2 doses of <i>Heplisav-B</i> followed by a QUANTITATIVE <i>Hepatitis B Surface Antibody (titer)</i> preferably drawn 4-8 weeks after 3 rd dose. If negative, give a 4 th dose and repeat a titer in 4-8 weeks. If negative complete the remainder of the second series followed by another titer drawn 4-8 weeks after the last dose of the second series. If <i>Hepatitis B Surface Antibody</i> is still negative after a secondary series, additional testing including <i>Hepatitis B Surface Antigen</i> should be performed. See: http://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf for more information. Documentation of Chronic Active Hepatitis B is for rotation assignments and counseling purposes only.				Copy Attached
Primary Hepatitis B Series Heplisav-B only requires two doses of vaccine followed by antibody testing	3-dose vaccines (<i>Energix-B, Recombivax, Twinrix</i>) 2-dose vaccines (<i>Heplisav-B</i>)	3 Dose Series	2 Dose Series	<input type="checkbox"/>
	Hepatitis B Vaccine Dose #1	___/___/___	___/___/___	
	Hepatitis B Vaccine Dose #2	___/___/___	___/___/___	
	Hepatitis B Vaccine Dose #3	___/___/___		
	QUANTITATIVE Hep B Surface Antibody	___/___/___	_____ IU/ml	
Secondary Hepatitis B Series <u>Only If no response to primary series</u> Heplisav-B only requires two doses of vaccine followed by antibody testing		3 Dose Series	2 Dose Series	<input type="checkbox"/>
	Hepatitis B Vaccine Dose #4	___/___/___	___/___/___	
	Hepatitis B Vaccine Dose #5	___/___/___	___/___/___	
	Hepatitis B Vaccine Dose #6	___/___/___		
	QUANTITATIVE Hep B Surface Antibody	___/___/___	_____ IU/ml	
Hepatitis B Vaccine Non-responder <small>(If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)</small>	Hepatitis B Surface Antigen	___/___/___	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/>
	Hepatitis B Core Antibody	___/___/___	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/>
Chronic Active Hepatitis B	Hepatitis B Surface Antigen	___/___/___	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/>
	Hepatitis B Viral Load	___/___/___	_____ copies/ml	<input type="checkbox"/>
Additional Documentation				
<p>Some institutions may have additional requirements depending upon rotation, school requirements or state law. Examples include meningitis vaccine which is mandated in some states if you live in dormitory style housing. If you will be participating in an international experience you may also be required to provide proof of vaccines such as yellow fever or typhoid. Respiratory Fit Testing, etc</p>				
Vaccination, Test or Examination	Date	Result or Interpretation	Copy Attached	
Physical Exam (if required)	___/___/___			<input type="checkbox"/>
Respiratory Fit Testing	___/___/___			<input type="checkbox"/>
	___/___/___			<input type="checkbox"/>
	___/___/___			<input type="checkbox"/>
	___/___/___			<input type="checkbox"/>
	___/___/___			<input type="checkbox"/>
	___/___/___			<input type="checkbox"/>



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TUBERCULOSIS SCREENING – Results of last (2) TSTs (PPDs) or (1) IGRA blood test are required **regardless** of prior BCG status. If you have a history of a positive TST (PPD) >10mm or IGRA please supply information regarding any evaluation and/or treatment below. You only need to complete ONE section.

Skin test or IGRA results should not expire during proposed elective rotation dates
or
must be updated with the receiving institution prior to rotation.

Tuberculosis Screening History

Please complete only one TB section based on your history	Section A		Date Placed	Date Read	Result	Interpretation	Copy Attached	
	Negative Skin or Blood Test History <small>Last two skin test or IGRAs required</small>	TST #1				____ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	
		TST #2				____ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	
		TST #3				____ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	
		TST #4				____ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	
	<small>T-spots or QuantiFERON TB Gold blood tests for tuberculosis</small> <small>Use additional rows as needed</small>			Date		Result		
		Quantiferon TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>				<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
		Quantiferon TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>				<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
		Quantiferon TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>				<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
		Quantiferon TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>				<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
	Section B		Date Placed	Date Read	Result			
	History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test <small>IGRAs include T-spots or QuantiFERON TB Gold blood tests for tuberculosis</small>	Positive TST				_____ mm		
				Date		Result		
		Quantiferon TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>				<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
		Chest X-ray				_____		
Treated for latent TB?				<input type="checkbox"/> Yes <input type="checkbox"/> No				
If treated for latent TB, list medications taken:								
Total Duration of treatment latent TB?				_____ Months				
Date of Last Annual TB Symptom Questionnaire								
Section C				Date				
History of Active Tuberculosis	Date of Diagnosis							
	Date of Treatment Completed							
	Date of Last Annual TB Symptom Questionnaire							
	Date of Last Chest X-ray							



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Additional Information

MUST BE COMPLETED BY YOUR HEALTH CARE PROVIDER OR INSTITUTIONAL DESIGNEE:

Authorized Signature:		Date:
Printed Name:		Office Use Only
Title:		
Address Line 1:		
Address Line 2:		
City:		
State:		
Zip:		
Phone: () _____ - _____	Ext: _____	
Fax: () _____ - _____		
Email Contact:		

*Sources:

- [Hepatitis B In: Centers for Disease Control and Prevention. Epidemiology and Prevention of Vaccine-Preventable Diseases. Hamborsky J, Kroger A, Wolfe S, eds. 13th ed. Washington D.C. Public Health Foundation, 2015](#)
- [Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices \(ACIP\), MMWR, Vol 60\(7\):1-45](#)
- [CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management, MMWR, Vol 62\(RR10\):1-19](#)
- [Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices, MMWR Vol 67\(1\):1-31](#)