

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 test (IGRA or TST) and Tuberculosis Symptom Evaluation should be done within a year prior to clinical start date. Tuberculosis Symptom Evaluation can be found in the Forms section of the Patient Portal.
- 3) Individual TB Risk Assessment must be completed via the Patient Portal through the Forms section.
- 4) T-spot IGRA Tuberculosis blood tests are only accepted if performed in the US.
- 5) All lab reports (for titers, IGRAs, etc.) must be uploaded onto the Patient Portal, and all lab reports must be in English.
- 6) Visit our website at campushealth.tulane.edu/immunizations.
- 7) **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 immunizationoffice for assistance at immunizations@tulane.edu.)*
- 8) **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).
- 9) Next, use the **Upload Documents** link to upload your scanned copy of the completed form along with any necessary lab reports.
- 10) 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.
- 11) **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.
- 12) 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.
- 13) 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 -2 doses of MMR vaccine	MMR Dose #1				
	MMR Dose #2				
Option 2	Vaccine or Test	Date			
Measles -2 doses of vaccine or positive serology	Measles Vaccine Dose #1		Serology Results		<input type="checkbox"/>
	Measles Vaccine Dose #2		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml	
Mumps -2 doses of vaccine or positive serology	Mumps Vaccine Dose #1		Serology Results		<input type="checkbox"/>
	Mumps Vaccine Dose #2		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml	
Rubella -1 dose of vaccine or positive serology			Serology Results		<input type="checkbox"/>
	Rubella Vaccine		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Serologic Immunity (IgG antibody 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 dates of last Td and Tdap					
	Tdap Vaccine (Adacel, Boostrix, etc)				<input type="checkbox"/>
	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		<input type="checkbox"/>
	Varicella Vaccine #2		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml	
Influenza Vaccine - 1 dose annually each fall					
Date of last dose		Date			<input type="checkbox"/>
	Flu Vaccine				
COVID-19 Vaccine - 1 dose of updated (2023-2024 Formula) vaccine if previously vaccinated with any COVID-19 Vaccine.		Date			
	Updated Pfizer-BioNTech COVID-19 vaccine				<input type="checkbox"/>
	Updated Moderna COVID-19 vaccine				
	Novavax COVID-19 vaccine (2 doses given 3 weeks apart if not previously vaccinated with any COVID-19 Vaccine)				

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Name: _____ Date of Birth: _____
 (Last, First, Middle Initial) (mm/dd/yyyy)

Hepatitis B Vaccination - 3 doses of Engerix-B, PreHevbrio, Recombivax HB or Twinrix vaccines or 2 doses of Heplisav-B vaccine followed by a QUANTITATIVE Hepatitis B Surface Antibody test drawn 4-8 weeks after last vaccine dose. A test titer ≥ 10 mIU/mL is positive for immunity. If the test result is negative, CDC guidance recommends that HCP receive one or more additional doses of Hepatitis B vaccine up to completion of a second series, followed by a repeat titer test 4-8 weeks after the last vaccine dose. If a single additional vaccine dose does not elicit a positive test result, administer additional vaccine doses to complete the second series using the schedule approved for the primary series of a given product. If the Hepatitis B Surface Antibody test is negative (<10 mIU/mL) after receipt of 2 complete vaccine series, a "non-responder" status is assigned. See: http://dx.doi.org/10.15585/mmwr.rr6701a1 for additional information.				Copy Attached	
Primary Hepatitis B Series Heplisav-B only requires two doses of vaccine followed by antibody testing	3-dose vaccines (Engerix-B, PreHevbrio, Recombivax HB, Twinrix) or 2-dose vaccine (Heplisav-B)	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 Test		_____ mIU/ml		
Additional doses of Hepatitis B Vaccine <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		
	Hepatitis B Vaccine Dose #4				
	Hepatitis B Vaccine Dose #5				
	Hepatitis B Vaccine Dose #6				
	QUANTITATIVE Hep B Surface Antibody Test		_____ mIU/ml		
Hepatitis B Vaccine Non-responder	If the Hepatitis B Surface Antibody test is negative (titer less than 10 mIU/mL) after a primary and repeat vaccine series, vaccine non-responders should be counseled and evaluated appropriately. Certain institutions may request signing an "acknowledgement of non-responder status" document before clinical placements.				
Additional Documentation					
<u>Some institutions</u> 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.					
Vaccination, Test or Examination	Date	Result or Interpretation			
Physical Exam (if required)					

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Name: _____ **Date of Birth:** _____
(Last, First, Middle Initial) (mm/dd/yyyy)

TUBERCULOSIS (TB) SCREENING – All U.S. healthcare personnel are screened pre-placement for TB. Two kinds of tests are used to determine if a person has been infected with TB bacteria: the TB skin test (TST) and the TB blood test (IGRA). Results of the last two TSTs or one IGRA blood test are required regardless of prior BCG status. If the TST method is used, record the dates and results of two 1-step annual TSTs over the last two years, or of one 2-step TST protocol (two TSTs performed with the second TST placed at least 1 week after the first TST read date). In either series, the second TST must have been placed within the past 12 months prior to clinical duties, and must have been performed in the U.S. If you have a history of a positive TST (PPD) >10mm or a positive IGR blood test, please supply information regarding any evaluation and/or treatment below. You only need to complete ONE section, A or B.

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
	History of Negative TB Skin Test or Blood Test <u>T-spots or QuantiFERON TB Gold blood tests for tuberculosis</u> Use additional rows as needed	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
				Date	Result	
		QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)			<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
		QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)			<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
	Section B		Date Placed	Date Read	Result	
	History of Positive Skin Test or Positive Blood Test	Positive TST			_____ mm	
				Date	Result	
		QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)			<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
		Chest X-ray*			*Provide documentation or result	
		Treated for latent TB infection (LTBI)?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Date of Last Annual TB Symptom Questionnaire				



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Additional Information

MUST BE SIGNED BY A LICENSED HEALTHCARE PROFESSIONAL OR DESIGNEE:

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

*Sources:

1. [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](#)
2. [Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices \(ACIP\), MMWR, Vol 60\(7\):1-45](#)
3. [CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management, MMWR, Vol 62\(RR10\):1-19](#)
4. [Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices, MMWR Vol 67\(1\):1-31](#)
5. [Sosa LE, Nijje GL, Lobato MN, et.al. Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from National Tuberculosis Controllers Association and CDC, 2019. MMWR2019;68:439-443. \[https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s_cid=mm6819a3_w\]\(https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s_cid=mm6819a3_w\)](#)