Campus Health
TULANE UNIVERSITY

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**		☐
	Measles Vaccine Dose #2		Qualitative Titer Results:	❑ Positive ❑ 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**		☐
	Mumps Vaccine Dose #2		Qualitative Titer Results:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml	
Rubella *-1 dose of vaccine or positive serology*			**Serology Results**		
	Rubella Vaccine		Qualitative Titer Results:	❑ Positive ❑ 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)				☐
	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:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml	
Influenza Vaccine - *1 dose annually each fall*					
Date of last dose		**Date**			☐
	Flu Vaccine				
COVID-19 Vaccine - *primary series of two (2) doses and booster dose*		**Date**	**Company or Trade Name**		
	COVID-19 Vaccine #1				☐
	COVID-19 Vaccine #2				
	COVID-19 Booster Bivalent Vaccine				

AAMC Standardized Immunization Form

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

Hepatitis B Vaccination - *3 doses of Engerix-B, PreHevbrio, Recombivax 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 ≥10mIU/mL is positive for immunity. If the test result is negative, repeat another Hepatitis B vaccine series followed by a repeat test titer. If the Hepatitis B Surface Antibody test is negative after the repeat vaccine series, a "non-responder" status is assigned. See: http://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf for more information.*				Copy Attached
Primary Hepatitis B Series Heplisav-B only requires two doses of vaccine followed by antibody testing	3-dose vaccines (Energix-B, PreHevbrio, Recombivax, Twinrix) or 2-dose vaccine (Heplisav-B)	**3 Dose Series**	**2 Dose Series**	☐
	Hepatitis B Vaccine Dose #1			
	Hepatitis B Vaccine Dose #2			
	Hepatitis B Vaccine Dose #3			
	QUANTITATIVE Hep B Surface Antibody Test		_____ mIU/ml	
Repeat Hepatitis B Series *Only If no response to primary series* 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			
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.*			
Vaccination, Test or Examination	**Date**	**Result or Interpretation**	
Physical Exam (if required)			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

AAMC Standardized Immunization Form

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. Results of the last (2) TB Skin Tests (TSTs)) or (1) IGRA blood test are required* ***regardless*** *of prior BCG status. The 2-step TST protocol must have been placed within the past 12 months prior to clinical duties, and must have been performed in the U.S. The second TST must be placed at least 1 week after the first TST read date. If you have a history of a positive TST (PPD)≥10mm or a positive IGRA 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	**TST #1**			____ mm	❑ Pos ❑ Neg ❑ Equiv
	TST #2			____mm	❑ Pos ❑ Neg ❑ Equiv
			Date	**Result**	
T-spots or QuantiFERON TB Gold blood tests for tuberculosis	**QuantiFERON TB Gold or T-Spot** (Interferon Gamma Releasing Assay)			❑ Positive ❑ Negative ❑ Indeterminate	
Use additional rows as needed	**QuantiFERON TB Gold or T-Spot** (Interferon Gamma Releasing Assay)			❑ Positive ❑ Negative ❑ 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)			❑ Positive ❑ Negative ❑ Indeterminate
	Chest X-ray*			*Provide documentation or result
	Treated for **latent** TB infection (LTBI)?			❑ Yes ❑ No
	Date of Last Annual TB Symptom Questionnaire			

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(Last, First, Middle Initial) (mm/dd/yyyy)

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, Nijie 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