ENVIRONMENTAL HEALTH & SAFETY
UNIVERSITY of WASHINGTON

# Required Immunizations for Health Sciences Students
# 2015-2016, University of Washington

**Part I. STUDENT INFORMATION (please type or print legibly) This section of the form to be completed by student.**

Name: _____ (Last) _____ (First) Major/Program: _____

DOB: ___/___/___ (Mo Day Yr) UW Student Number: _____ Quarter Starting: _____

**REQUIRED:** The University of Washington Environmental Health & Safety Department administers the Health Sciences Immunization Program (HSIP). The HSIP reviews students' documentation of immunizations and other protections, such as tuberculosis surveillance; makes recommendations regarding requirements not yet met; processes records; and holds registration for non-compliance with the requirements. The HSIP follows the recommendations of the Centers for Disease Control and Prevention. It is the student's responsibility to meet any requirements of a practice site that may differ from those covered by the HSIP, which are listed on this form. The HSIP discusses, shares, and communicates students' compliance status and related information to their school/program prior to and during placement at practicum or clinical sites of practice. This may include any or all information included on this form, and annual required updates as described. Documentation occurs in a combined student/employee electronic database and is held confidential in accordance with applicable laws and regulations.
By signing below I acknowledge I have read and agree to the above.

✶**SIGNATURE:** ✶ **(required)** _____ **DATE:** ___/___/___ (Mo Day Yr)

***Please attach copies, not original records—all documents used for administrative purposes will be destroyed. Always keep the original or a copy for your personal records. This form must be completed in its entirety and received prior to your deadline or an extra fee may be charged.***
**Return by TIFF or PDF attachment to myshots@uw.edu (preferred)** ***or fax to 206.616.8434***

**Part II. DOCUMENTATION OF IMMUNIZATION REQUIREMENTS: To be completed ONLY by Health Care Provider (HCP)**
**This section of the form should not be signed by student, parent, or spouse.**

**Instructions for HCPs: Documentation of immunity (AS DEFINED ON THIS FORM) is REQUIRED. Please initial each section; signature and credentials are requested at the end of the form. Lab reports must be submitted for titers.** ***All sections must be completed*** **for school acceptance.**

1. **CHILDHOOD IMMUNIZATIONS:** A Primary childhood or adult series with DTaP/DTP/DT/Td **is required**. Students are expected to have received the childhood polio series. An adult IPV booster is an acceptable alternative.

## The following question must be answered:

**Were childhood immunizations completed? (i.e. DPT/Polio; ok to have completed in adulthood as explained above)**

YES ☐ NO ☐ **If YES, is this information by:** VERBAL REPORT ☐ (records NOT reviewed) ***OR*** DOCUMENTED RECORDS ☐ (records reviewed) **Official's initials:** _____

2. **MEASLES (RUBEOLA):** ***TWO*** doses of measles-containing vaccine (*regardless of birthdate*), or a positive IgG antibody titer. The doses must be on or after age 12 months, at least one month apart, and a live virus vaccine after 01/01/68, given without Immune Globulin. MMR must have been received in 1971 or later.

#1 ___/___/___ (Mo Day Yr) Indicate type: ☐ Measles (single antigen vaccine) ☐ Measles/Rubella ☐ Measles/Mumps/Rubella (MMR not available in U.S. until 1971)

**AND**

#2 ___/___/___ (Mo Day Yr) Indicate type: ☐ Measles ☐ Measles/Rubella ☐ Measles/Mumps/Rubella

**OR** Positive Rubeola IgG Antibody Titer: **(LAB REPORT REQUIRED)** ___/___/___ (Mo Day Yr) **Official's initials:** _____

**If two MMRs were not documented in #2, please complete the following; otherwise skip to question #5 on the next page.**

3. **MUMPS:** ***TWO*** doses of mumps-containing vaccine (*regardless of birthdate*) or a positive IgG antibody titer. The doses must have been received on or after the age of 12 months and at least one month apart. Mumps alone must have been live virus vaccine received after 01/01/80.

#1 ___/___/___ (Mo Day Yr) (must be after 1/1/1980) ***AND*** #2 ___/___/___ (Mo Day Yr) ***OR*** Positive Mumps IgG Ab titer: **(LAB REPORT REQUIRED)** ___/___/___ (Mo Day Yr)

**Official's initials:** _____

4. **RUBELLA (GERMAN MEASLES):** ***ONE*** dose of rubella (single antigen) vaccine on or after 12 months of age or a positive IgG antibody titer.

___/___/___ (Mo Day Yr) ***OR*** Positive Rubella IgG Ab titer: **(LAB REPORT REQUIRED)** ___/___/___ (Mo Day Yr) **Official's initials:** _____

**NAME:** _____ **UW STUDENT NUMBER:** _____

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**5.** **VARICELLA:** ***TWO*** doses of varicella-containing vaccine given on or after 12 months of age and at least one month apart, or positive Varicella IgG antibody titer. ***History of disease will NOT be accepted.*** **Only the vaccine or titer will meet requirements.**

#1 ___/___/___ (Mo Day Yr) ***AND*** #2 ___/___/___ (Mo Day Yr) ***OR*** Positive Varicella IgG Ab titer: ___/___/___ (Mo Day Yr) **(LAB REPORT REQUIRED)**

(Varicella vaccine not available in U.S. until 3/1995)

**Official's initials:** _____

**6.** **TETANUS-DIPHTHERIA-PERTUSSIS:** One dose of **Tdap is required within the past 10 years.** This vaccine became available in the U.S. in June 2005. **Note**: **Td is a different vaccine, and *does not* substitute for Tdap**. Titers are ***NOT*** accepted in lieu of Tdap vaccine.

Tetanus-Diphtheria-acellular Pertussis **(Tdap)** (One dose needed within past 10 years) Date: ___/___/___ (Mo Day Yr) **Official's initials:** _____

**7.** **HEPATITIS B:** ***THREE DOCUMENTED DOSES*** of vaccine ***AND*** **a positive QUANTITATIVE Hepatitis B surface antibody titer (HBsAb, or anti-HBs)**. The reference range is indicated on the lab report for quantitative results; a positive titer is equivalent to 10 mIU/mL or higher. Students who just started the series may note they are "in process" and forward documentation of further doses **and titer results** as soon as they become available. Those who have **incomplete or no documentation of their series must complete a valid 3-dose series followed by the titer**. It is recommended that students complete their 3-dose series prior to patient (or body fluid) contact in practicum/clinical settings.

Dose #1 ___/___/___ (Mo Day Yr) Dose #2 ___/___/___ (Mo Day Yr) Dose #3 ___/___/___ (Mo Day Yr) Dose #4 (optional, see below) ___/___/___ (Mo Day Yr)

**Official's initials:** _____

**Additional doses**: If more than 2 years have elapsed since a dose was given, we recommend an extra dose to boost antibodies to a detectable level. Then, draw the quantitative HbsAb titer 4-6 weeks later. If this titer is negative, testing for the **antigen** (HBsAg), a test of "carrier" status or prior exposure, may be indicated. If the HBsAg is negative, continue completing a 2nd series. Then re-check the HbsAb titer 4-6 weeks later. See the following algorithm for further details: http://www.immunize.org/catg.d/p2108.pdf

***AND*** ***(Required):*** **Positive quantitative Hepatitis B surface antibody (anti-HBs) titer:**

Date: ___/___/___ (Mo Day Yr) Indicate Reference Range Used: ☐ Int'l Units ***OR*** ☐ Index Value **Official's initials:** _____

**(LAB REPORT REQUIRED)**

**HEPATITIS B NON–RESPONDERS** are those with a negative HBsAb **after *2 documented 3-dose series*** of vaccine. In addition to proof of series completion and negative titers, Non-responders must submit proof of a counseling visit with a health professional to discuss their status and implications, such as immunizations necessary at time of blood borne pathogen exposures and need for rigorous adherence to standard precautions.

**HEPATITIS B DISEASE:** Those who have had the disease ***must attach the following laboratory results***: Hepatitis B surface antibody, Hepatitis B surface antigen, and Hepatitis B core antibody. Students who are carriers (positive HBsAg) must show proof of a personal counseling visit with a provider about their carrier status (including discussion of need for rigorous adherence to standard precautions).

**8.** **If submitting this form after 8/15/15: Complete the following IF YOU ARE IN A PROGRAM THAT DOES NOT PROVIDE FLU VACCINE ON CAMPUS (i.e. Nursing, MEDEX, Social Work, Speech & Hearing, execMPH). If unsure, check with your program.**

**INFLUENZA:** Seasonal influenza vaccine is required between August and November each year. Waivers are given only for students who have valid medical contraindications. A waiver request form (available from HSIP's website) must be submitted annually. NOTE: Egg allergy is no longer a contraindication for most. Egg-free vaccine is available.

2015-2016 seasonal influenza vaccine Date: ___/___/___ (Mo Day Yr) Indicate type: ☐ inactivated/injected vaccine ☐ live/nasal ☐ recombinant

**(On or after 8/15/15, for students in Nursing, MEDEX, Social Work, Speech& Hearing, execMPH)**

**Official's initials:** _____

## HEALTH CARE PROVIDER INFORMATION

***NOTE: This section must be completed by HCP (MD, DO, NP, PA, RN or other appropriate designee) for authentication. Not to be completed by student or relative.***

**I certify the accuracy of all immunizations and other information detailed on this 2-page form:** _____ **HCP's Signature** _____ **Date**

HCP's name printed/stamp of facility: _____Phone # _____

**Return by TIFF or PDF attachment to myshots@uw.edu (preferred) or fax to 206.616.8434** 04/01/15