UCF HEALTH SERVICES

UNIVERSITY OF CENTRAL FLORIDA
College of Medicine

MANDATORY IMMUNIZATION FORM

Registration at UCF COM will be blocked until documentation of the following immunizations is received and accepted. REQUIREMENTS ARE SUBJECT TO CHANGE WITHOUT PRIOR NOTICE BASED UPON RECOMMENDATIONS FROM THE CDC. You will be notified of changes as soon as practical.

Print Name:

Immunizations REQUIRED for ALL Students.

			REQUIRED DOCUMENTATION
1.	**Measles, Mumps, Rubella (MMR) COMBINED** Documentation of two MMR vaccines (at least 28 days apart) after 12 months of age.	MMR vaccine Dose One	Vaccine Document Copy
		MMR vaccine Dose Two	
	OR **Measles, Mumps, Rubella (MMR) SEPARATE**		
2.	**Rubella (German Measles)** Serologic documentation of a positive Rubella immune titer OR immunization with live Rubella or MMR vaccine after 01/01/80 OR two immunizations with live Rubella or MMR after 12 months of age.	Rubella Titer (IgG Blood Test)	Lab Report Copy
		OR Two live Rubella after 01/01/80	Vaccine Document Copy
	Rubeola (10 Day Measles) Serologic documentation of a positive Rubeola immune titer OR two immunizations with live Rubeola OR two MMR vaccines after 12 months of age.	Rubeola Titer (IgG Blood Test)	Lab Report Copy
		OR Two live Rubeola	Vaccine Document Copy
	Mumps Serologic documentation of a positive Mumps immune titer OR immunization with at least two doses of live Mumps or MMR vaccine after 12 months of age.	Mumps Titer (IgG Blood Test)	Lab Report Copy
		OR Two live Mumps vaccines	Vaccine Document Copy
3.	**Meningitis** Documentation of receiving one dose of meningitis vaccine (Menomune/Menactra). Persons aged 21 years or younger should have documentation of receipt of a dose of meningococcal conjugate vaccine not more than 5 years before enrollment. If the primary dose was administered before the 16th birthday, a booster dose should be administered. The minimum interval between doses of meningococcal conjugate vaccine is 8 weeks.	Meningococcal conjugate vaccine (MCV4)	Vaccine Document Copy
4.	**Hepatitis B** Serologic documentation of a positive (quantitative) Hepatitis B surface antibody titer following completion of the Hepatitis B vaccination series of three (3) injections.	Surface Antibody Titer (IgG) (quantitative) **OR**	Lab Report Copy
		Hepatitis Vaccine Series **AND**	Vaccine Document Copy
		Surface Antibody Titer (IgG) (quantitative) 60 days after vaccine series	Lab Report Copy
5.	**Tetanus/Diphtheria/Pertussis (Tdap)** Documentation of Tetanus/Diphtheria/Acelluar Pertussis booster. Note: A 2 year interval between Td (Tetanus/diphtheria booster) and Tdap is suggested to reduce the risk of reactions following vaccination. If a Td Booster was received within the last two years, provide documentation of the Td Booster at this time; at the end of the 2 year period you will need to obtain a Tdap Booster and provide documentation upon completion.	Tdap (Adacel) vaccine **OR**	Vaccine Document Copy
		Ineligible for Tdap vaccine as Tetanus/Diphtheria and/or Pertussis vaccine was received within **last 2 years.**	Vaccine Document Copy
6.	**VARICELLA (Chicken Pox)** Documentation of a positive Varicella titer OR two Varicella immunizations (given 4 to 8 weeks apart). This requirement is satisfied only by a positive titer or the vaccine series. A history of chicken pox DOES NOT satisfy this requirement.	Varicella Titer (IgG Blood Test)	Lab Report Copy
		OR Varicella vaccine series	Vaccine Document Copy
7.	**Tuberculosis** Documentation of a PPD skin test within six months of visit to UCF. Documentation of a current chest x-ray for all persons with a history of a positive PPD skin test (within past twelve months). Quantiferon-Gold TB test is acceptable for those students with a history of a positive PPD.	PPD (within past 6 months)	Skin Test Document Copy
		If positive PPD or positive history, last CXR	Radiology Report **AND** Page 3
		History of INH	
		Received BCG vaccine Yes ☐ No ☐	Vaccine Document Copy
8.	**INFLUENZA (Flu)** Documentation of the annual Influenza vaccination. If you have not already received it, this immunization should be obtained in the Fall of each year as made available.	Influenza virus vaccine	Vaccine Document Copy

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Tuberculosis Screening Questionnaire

Please complete the following information **if** you have a history of a **POSITIVE** TB Skin Test:

Name: _____ _____ _____ Male ❒ Female ❒
Last First Initial

Have you ever received BCG?	Yes ☐ No ☐	If Yes, date of BCG:_____
Date of last PPD Skin Test:		_____/_____/_____
Did you take any medication associated with a positive TB Skin Test?	Yes ☐ No ☐	If Yes, dates:_____
Date of last chest X-Ray:		_____/_____/_____

Please check (✓) if you are having any of the following **unexplained** symptoms for three to four weeks or longer:

Unexplained fatigue	❒ Yes	❒ No	Night sweats (drenching)	❒ Yes	❒ No
Unexplained weight loss	❒ Yes	❒ No	Persistent cough	❒ Yes	❒ No
Loss of appetite	❒ Yes	❒ No	Spitting/Coughing up blood	❒ Yes	❒ No
Fever (usually at night)	❒ Yes	❒ No	Chest pain	❒ Yes	❒ No

Health Care Provider Certification

HEALTH CARE PROVIDER CERTIFICATION AND ADDRESS

_____
Printed Name

_____
Practice Name

_____
Street

_____
City, State, Zip Code

_____ _____
Signature *Date*

An official stamp from a doctor's office, clinic or health department must appear here or on the official document(s) attached or this form will not be approved.

RETURN TO:
Office of Student Affairs
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Orlando, Florida 32827
(407) 266-1353
FAX: (407) 266-1399