Exhibit B

UCR School of Medicine
Annual—Immunization Confirmation (Annual-IC)

UCR-SOM policy for medical students, visiting students, faculty, and support staff assigned any proportion of time *in patient care environments*

Health Screening Requirements: Immunization/Infectious Disease Status:

Name: _____ Student ID#: _____

Birth date: _____

1. **PPD (Mantoux test for Tuberculosis)**
   If you had a PPD test for Tuberculosis, please record the result here.
   Date of Administration: _____
   Date Read: _____ Result: ☐ positive ☐ negative
   _____ mm Induration

1. Have you previously had a Tuberculin skin test (PPD)?	☐No ☐Yes
2. Did you ever have a positive skin test?	☐No ☐Yes
3. Have you received BCG (TB immunization) in the past? (If yes, date___/___/___)	☐No ☐Yes
4. Have you had MMR or Varicella vaccine within the last 60 days? (If yes, date (_____/_____/_____)	☐No ☐Yes
5. Do you have a persistent cough (lasting 3 weeks or more)?	☐No ☐Yes
6. Do you cough up blood?	☐No ☐Yes
7. Do you have persistent, unexplained fevers or night sweats?	☐No ☐Yes
8. Do you have a rash? If "Yes", for how long? _____	☐No ☐Yes
9. Do you have unintentional weight loss fatigue, or loss of appetite?	☐No ☐Yes
10. Do you have any reason to believe that your immune system may have been altered or damaged due to any of the following conditions or medications, which could increase you risk for tuberculosis (i.e. cancer; sarcoidosis; HIV/ AIDS; chemotherapy; chronic steroid therapy or medications to prevent transplant rejection)? **Note: HIV infection and other medical conditions may cause a TB (PPD) skin test to be negative even when TB infection is present.**	☐No ☐Yes

2. Chest X-ray (for Tuberculosis screening)
   If you have had a chest x-ray performed as a follow-up to a positive PPD result, please record the result here:
   Date of Administration: _____ Result: ☐ positive ☐ negative

3. **Proof of annual flu vaccination**

   The following documents are acceptable and must contain the individual's name, the location of the vaccination provider, the name of the vaccine and the date administered. Failure to provide at least 1 of the below requirements will result in disciplinary action:

   i. A letterhead note or script with your doctor's signature
   ii. An updated yellow vaccination card or vaccination record from your doctor's office
   iii. A receipt or signed document as proof of flu vaccine administration from a

pharmacist or outside vendor

iv. If an individual declines to obtain a flu vaccine, a written and signed consent is required to reflect the decision of declination by submitting the UCR SOM Informed Declination form (Exhibit C) to his or her respective unit for inclusion in their personnel file.

Infectious disease status reviewed and up to date ☐ (check if complete)

Signature of Clinician: _____ Date: _____

Print Name and Title: _____ Telephone: _____

Address of Clinician: _____

Exhibit C

UCR School of Medicine
Informed Declination Form

I DO NOT WANT A FLU SHOT.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease; on average, 36,000 Americans die every year from influenza-related causes.
- Influenza virus may be shed for up to 24 hours before symptoms begin, increasing the risk of transmission to others.
- Some people with influenza have no symptoms, increasing the risk of transmission to others.
- Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months. In California, influenza usually begins circulating in early January and continues through February or March.
- I understand that the influenza vaccine cannot transmit influenza and it does not prevent all disease.
- I have declined to receive the influenza vaccine for the season. I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention for all students and healthcare workers in order to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community.

Knowing these facts, I choose to decline vaccination at this time. ***I acknowledge that I have read this informed declination for Influenza Vaccination in its entirety and fully understand it.***

Print Name:_____

Signature:_____

Date:_____