

**DO NOT ATTACH A SEPARATE VACCINATION RECORD. All dates must in MM-DD-YYYY format.**

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**Part 2: Required for all Health Professions Students****4. TUBERCULOSIS (TB) – ± Required for Health Professions Students – All other students to complete TB Risk Assessment Form (in packet)**

<b>STEP 1: TB Blood Test/IGRA</b>		<b>OR</b>	<b>TB Skin Test (PPD)</b>	<b>STEP 2: DO NOT COMPLETE UNLESS POSITIVE TB SKIN TEST OR TB BLOOD TEST</b>	
<input checked="" type="checkbox"/> QuantiFERON <input checked="" type="checkbox"/> T-Spot Date: <u>01-01-2023</u> MM DD YYYY RESULT: <input checked="" type="checkbox"/> NEG <input checked="" type="checkbox"/> POS* Required: <input checked="" type="checkbox"/> Attach lab results.		Date planted: <u>06-15-2023</u> MM DD YYYY Date read: <u>06-30-2023</u> MM DD YYYY Interpretation: <input checked="" type="checkbox"/> NEG <input checked="" type="checkbox"/> POS* mm of induration: <u>9</u>		<b>CHEST XRAY</b> Required if past or current positive TB skin or blood test. Not required if completed medication treatment for TB. Chest X-ray Date: <u>01-01-2024</u> MM DD YYYY <input checked="" type="checkbox"/> Normal <input checked="" type="checkbox"/> Abnormal	
				<b>TB TREATMENT</b> <input checked="" type="checkbox"/> Latent TB Infection <input checked="" type="checkbox"/> Active TB Infection Date(s): <u>06-30-2023</u> MM DD YYYY List Medication(s): <u>None</u>	

**5. COVID-19 VACCINATION – ± Required for Health Professions Students – Strongly encouraged for all other students.**  
 • Please submit documentation of prior vaccine doses **AND at least one (1) dose of 2023-2024 updated formulation.**

<b>PRIMARY DOSE #1</b>	<b>PRIMARY DOSE #2 (skip if J&amp;J vaccine)</b>	<b>COVID-19 updated 2023-2024 dose</b>
Date: <u>03-15-2021</u> MM DD YYYY <input checked="" type="checkbox"/> Moderna <input checked="" type="checkbox"/> Pfizer <input checked="" type="checkbox"/> Johnson & Johnson/Janssen <input checked="" type="checkbox"/> Novavax <input checked="" type="checkbox"/> Other WHO approved Name: <u>Bob</u>	Date: <u>04-15-2021</u> MM DD YYYY <input checked="" type="checkbox"/> Moderna <input checked="" type="checkbox"/> Pfizer <input checked="" type="checkbox"/> Novavax <input checked="" type="checkbox"/> Other WHO approved Name: <u>Sam</u>	Date: <u>10-13-2023</u> MM DD YYYY <input checked="" type="checkbox"/> Moderna <input checked="" type="checkbox"/> Pfizer <input checked="" type="checkbox"/> Novavax Name: <u>Test</u>

**6. Hepatitis B Immunity – ± Required for Health Professions Students – Not required for all other students.**  
 Documentation of a COMPLETE series of Hepatitis B vaccination AND quantitative antibody titer.

<b>Hepatitis B Vaccine (enter name)</b>	<b>Date of Dose #1:</b>	<b>Date of Dose #2:</b>	<b>Date of Dose #3 (if applicable):</b>	<b>Hep B Surface Antibody Titer (QUANTITATIVE)</b>
	<u>01-01-2022</u> MM DD YYYY	<u>03-01-2022</u> MM DD YYYY	<u>05-01-2022</u> MM DD YYYY	<u>06-01-2023</u> MM DD YYYY
				Result: <u>12</u> IU / sc <input checked="" type="checkbox"/> Immune <input checked="" type="checkbox"/> Not Immune

**7. TETANUS-DIPHTHERIA-PERTUSSIS (Tdap) – ± Required for Health Professions Students – Not required for all other students.**

<b>Only Tdap is accepted within the past 10 years</b>	<b>Date of most recent Tdap dose:</b>
	<u>02-10-2024</u> MM DD YYYY

**8. INFLUENZA VACCINATION: ± Required for Health Professions Students, documentation to be submitted during flu season. Recommended but not required for all other students.**

<b>Influenza (Flu) Vaccination</b>	<b>Date of Influenza Vaccination:</b>
	<u>10-13-2023</u> MM DD YYYY
Must be between September and March of CURRENT academic year	

**Part 3: Recommended vaccines based on personal history – (please record if applicable)****OTHER VACCINES - NOT required**

<b>Hepatitis A Vaccine</b>	Date of Dose #1: <u>01-01-2006</u> MM DD YYYY	Date of Dose #2: <u>03-01-2006</u> MM DD YYYY		
<b>HPV Vaccine</b>	<input checked="" type="checkbox"/> HPV 4 <input checked="" type="checkbox"/> HPV 9	Date of Dose #1: <u>01-01-2004</u> MM DD YYYY	Date of Dose #2: <u>03-01-2004</u> MM DD YYYY	Date of Dose #3: <u>05-01-2004</u> MM DD YYYY
<b>Meningococcal Serogroup B Vaccine</b>	<input checked="" type="checkbox"/> Bexsero, 2 doses <input checked="" type="checkbox"/> Trumenba, 3 doses	Date of Dose #1: <u>01-01-2004</u> MM DD YYYY	Date of Dose #2: <u>03-01-2004</u> MM DD YYYY	Date of Dose #3 (if Trumenba): <u>05-01-2004</u> MM DD YYYY
<b>Yellow Fever</b>	<input checked="" type="checkbox"/> Yellow Fever <input checked="" type="checkbox"/> Stamaril	Date of Dose: <u>06-01-2010</u> MM DD YYYY		
<b>Typhoid</b>	Date of Dose: <u>06-01-2010</u> MM DD YYYY			


**Part 4: Medical Provider Certification of the Above Information**

<b>Medical Provider Name</b> <u>Dr Rubenstein</u>	<b>Medical Provider Signature</b>	<b>Date</b> <u>02-20-2024</u> Month Day Year
<b>Address (Include city and state)</b> <u>5 Pequod Pl. Westbrook, CT</u>		<b>Telephone</b> <u>203 555 1212</u>
<b>State or Country of Licensure / License #</b> <u>CT 1234567</u>		<b>Fax</b> <u>203 555 1213</u>

Form must be stamped or Signed by Medical Provider

Stamp

Signature

	
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