ENVIRONMENTAL HEALTH & SAFETY
UNIVERSITY of WASHINGTON

Required Immunizations for Health Sciences Students
2017-2018, 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 blocks registration for non-compliance with the requirements. The HSIP follows the recommendations of the Centers for Disease Control and Prevention, which may change during a student's enrollment. Students are required to comply with updated CDC recommendations until completion of their degree program. It is the student's responsibility to meet any requirements of a training site that may differ from those covered by the HSIP at the time of enrollment, which are listed on this form. The HSIP discusses, shares, and communicates students' compliance status and related information to their school/program and practicum or clinical training sites prior to and during placement. This may include any or all information included on this form, and any annual or other required updates as described.
By signing below, I authorize 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 EVIDENCED ON THIS FORM) is REQUIRED. Please initial each section; signature and credentials are required 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 IPV booster is an acceptable alternative.

The following question must be answered
Were childhood immunizations completed? (i.e. DTaP; 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 the age of 12 months, at least one month apart, and live virus vaccine given without Immune Globulin.

#1 ___/___/___ (Mo Day Yr) Indicate type: ☐ Measles/Mumps/Rubella (MMR MUST BE 1971 OR LATER) ☐ Measles ☐ Measles//Rubella (Measles or M/R dates must be 1968 or later)

AND

#2 ___/___/___ (Mo Day Yr) Indicate type: ☐ Measles/Mumps/Rubella (MMR MUST BE 1971 OR LATER) ☐ Measles ☐ Measles//Rubella (Measles or M/R dates must be 1968 or later)

OR Positive Rubeola IgG Antibody Titer: **ATTACH LAB REPORT** **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.

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

(Mumps single-antigen vaccine dates must be 1980 or later)

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: **ATTACH LAB REPORT** **Official's initials:** _____

PLEASE COMPLETE BOTH PAGES OF THIS 2-PAGE FORM

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 meets requirements.**

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

(Varicella vaccine dates must be 3/1/1995 or later if given in U.S.)

Official's initials: _____

6. **TETANUS-DIPHTHERIA-PERTUSSIS:** One dose of **Tdap is required** since June 2005. In addition, if Tdap was given more than 10 years ago, a **dose of Td-containing vaccine within the past 10 years is also required**. Titers are ***NOT*** accepted in lieu of Td/Tdap vaccine.

Tetanus-Diphtheria-acellular-Pertussis **(Tdap)**: ___/___/___ (Mo Day Yr) (One dose since June 2005 is required) ***AND***: ***IF INDICATED*** Tdap ☐ or Td ☐ (One dose in past 10 years) ___/___/___ (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)**. Reference ranges are indicated on the lab report for quantitative results; the standard for a positive titer is 10 mIU/mL or higher. Please indicate "in process" on form if student is just starting their series, and forward documentation of further doses **and titer results** as they become available. Those with **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.

CDC recommendations/rationale for boost and re-titer of health professionals are at: http://www.immunize.org/catg.d/p2109.pdf

AND ***(Required):*** **Positive quantitative/numeric value (mIU/mL/N/Conc/Index) Hepatitis B surface antibody (anti-HBs) titer:** **ATTACH LAB REPORT**

Official's initials: _____

HEPATITIS B NON–RESPONDERS are those with a negative HBsAb **after *2 documented 3-dose series*** of vaccine. Non-responders must submit documentation of two series, an appropriately timed negative HBsAb, and negative HBsAg. In addition, non-responders must show 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. **INFLUENZA:** Seasonal influenza vaccine is required. Documentation must be submitted separately to HSIP 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 individuals.

HEALTH CARE PROVIDER INFORMATION: ***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.***

Providers: Please do not make any modifications to this form after signing and dating. Further documentation (such as additional vaccine doses in a series, seasonal flu vaccine, or lab reports of titer results) should be submitted separately to myshots@uw.edu (or faxed to HSIP at 206-616-8434).

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

HCP's name printed and facility stamp: _____ **Phone #** _____

(Required in addition to signature and date)