University of Georgia
College of Pharmacy
Division of Experience Programs
706-542-5328 phone / 706-542-6022 fax

Name___________________________________ **Date of Birth** ______________ **Phone No.** ____________________

VACCINE	REQUIREMENT	INFORMATION REQUIRED:
MMR	•**2 Doses** #1 _____/_____/_____ #2 _____/_____/_____	• 2 MMRs or quantitative titer indicating immunity to each disease
Measles (Rubella)	• **2 Doses** #1 ____/____/____ #2____/____/_____ • **or Quantitative Titer (<u>attach results</u>)** ____/____/____	• 2 MMRs or quantitative titer indicating immunity to each disease • If titer completed, attach results.
Mumps	• **2 Doses** #1 ____/____/____ #2 ____/____/____ • **or Quantitative Titer (<u>attach results</u>)** ____/____/____	• 2 MMRs or quantitative titer indicating immunity to each disease • If titer completed, attach results.
Rubella (German Measles)	•**1 Dose** #1 ____/____/____ • **or Quantitative Titer (<u>attach results</u>)** ____/____/____	• 2 MMRs or quantitative titer indicating immunity to each disease • If titer completed, attach results.
Varicella (Chicken Pox)	• **2 Doses** #1____/____/____ #2____/____/____ • **or Quantitative Titer (<u>attach results</u>)** ____/____/____	• 2 shot vaccination series <u>OR</u> quantitative titer indicating immunity • **<u>Disease documentation insufficient</u>**
Tetanus and Diphtheria (Tdap)	**Tdap:** ____/____/____	• Evidence of one Tdap
Tetanus (Td)	**<u>Only Needed if More Recent Administration than Tdap</u>** • **Td** ____/____/____	• Must have Td booster every 10 years.
TB TESTING **Note: Two options available. If previous BCG vaccination, may consider using either QuantiFERON-TB Gold or TSPOT as preferred testing option**	**Can provide either of the following <u>from past 12 months</u>:** **Option 1: QuantiFERON-TB Gold or TSPOT (attach results)** ____/____/____ **Option 2: 2 Step TST** (2 TST tests given 1–3 weeks apart) Test 1: __/__/__ , ___mm Results: ☐negative ☐ positive Test 2: __/__/__ , ___mm Results: ☐negative ☐ positive **<u>If either of the options is positive</u>, complete the following:** • **<u>Chest x-ray report</u> (attach)** Date ____/____/____ X-ray result: ☐ negative ☐ abnormal • **Physician Treatment Statement** • **Documentation of Completed Treatment (if applicable)**	• <u>If previous BCG vaccination</u>, provide verification of vaccination and consider obtaining QuantiFERON-TB Gold or TSPOT.TB test as preferred testing option • **TST – Reaction of 10 mm or more is considered positive for healthcare workers** • Separate TST one month from live vaccines • **If TST positive with negative CXR, consider obtaining QuantiFERON-TB GOLD or TSPOT**
Hepatitis B →→→ →	• **3 Dose series** #1___/___/___ (Engerix-B or #2___/___/___ (Recombivax) #3___/___/___ **2 Dose Series** #1___/___/___ (Heplisav-B) #2___/___/___ • **<u>AND</u> Quantitative Titer (<u>Attach Results</u>)** ___/___/__ • **<u>If equivocal or negative titer, immediately restart series</u>**	• Either traditional (Engerix-B or Recombivax HB) 3 shot vaccination series over 6 months <u>OR</u> new (Heplisav-B) 2 shot series (1 month apart) • **<u>Must</u> provide** quantitative hepatitis B surface antibody titer indicating immunity (1 month after last vaccination). (CDC) • If equivocal or negative – restart series immediately with repeat titer 1 month after last vaccination

REQUIRED SIGNATURE OF PHYSICIAN OR HEALTH FACILITY <u>(MUST BE SIGNED TO BE VALID)</u>

Name ____ Address:

Signature ____________________________________

Date ____ Phone: