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 (attach results)** ____/____/____	• 2 MMRs or quantitative titer indicating immunity to each disease • If titer completed, attach results.
Mumps	**• 2 Doses** #1 ____/____/____ #2 ____/____/____ **• or Quantitative Titer (attach results)** ____/____/____	• 2 MMRs or quantitative titer indicating immunity to each disease • If titer completed, attach results.
Rubella (German Measles)	**•1 Dose** #1 ____/____/____ **• or Quantitative Titer (attach results)** ____/____/____	• 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 (attach results)** ____/____/____	• 2 shot vaccination series OR quantitative titer indicating immunity • **Disease documentation insufficient**
Tetanus and Diphtheria (Tdap)	**Tdap:** ____/____/____	• Evidence of one Tdap
Tetanus (Td)	**Only Needed if More Recent Administration than Tdap** **• Td** ____/____/____	• Must have Td booster every 10 years.
TB TESTING **Preferred option is an IGRA test (Quanteriferon or TSpot) based on healthsystem clearance requirements.** **If previous BCG vaccination, consider using an IGRA test (CDC recommendation)**	**Provide either of the following from past 12 months:** **Preferred Option: 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 ***If either of the options is positive, complete the following*:** • **Chest x-ray report (attach)** Date ____/____/____ X-ray result: ☐ negative ☐ abnormal • **Physician Treatment Statement** • **Documentation of Completed Treatment (if applicable)**	• **TST – Reaction of ≥10 mm 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___/___/___ • **AND Quantitative Titer (Attach Results)** ___/___/__ • **If equivocal or negative titer, immediately restart series**	• Either traditional (Engerix-B or Recombivax HB) 3 shot vaccination series over 6 months OR new (Heplisav-B) 2 shot series (1 month apart) • **Must 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 (MUST BE SIGNED TO BE VALID)

Name _____ Address:

Signature _____

Date _____ Phone: