University Clinical, Education and Research Associates (UCERA)
dba University Health Partners of Hawaii
The faculty practice of the John A. Burns School of Medicine

CONFIDENTIAL

IMMUNIZATION RECORDS

Name_____ Birth date _____

Tuberculosis Control (Required by Hawaii State Regulation)			
PPD (Mantoux)	Date Given	Date Read	Results (in mm)
Step 1			
Step 2			

U.S. students: A 2-Step PPD (**completed not less than one week and not more than three weeks apart**) within three (3) months of matriculation. Documentation of two (2) TB tests taken within one year, last within 3 months of matriculation will suffice.
Foreign students: Upon arrival, all students (including from Guam and the Pacific Basin) must have PPD administered within the United States; a follow-up x-ray may be required if test is positive. If you have had BCG >5 years previously, PPD is required.

If **positive**, please provide the date(s) and result(s) of current chest x-rays (must be taken year of matriculation) and the type and dates of drug therapy, if any.
Chest X-Ray: Date taken: _____Result: _____
Drug Therapy: Dates of treatment: _____Name of drug: _____

Required current immunizations and proof of immunity to: Measles; mumps, rubella, varicella and Hepatitis B (**positive serology required**); documentation of primary series for diphtheria, tetanus, polio, and Hepatitis B (**3 vaccinations**). Tdap immunization within 10 years is required. All students are required to submit documentation of all required immunizations.

Dates of Immunizations (mo/yr)					
Vaccine/Disease	**Initial Series**	**Booster**	**Booster**	**Booster**	**Booster**
MMR - 2 doses					
Tetanus/Diphtheria (Tdap booster required)					
Polio					
Hepatitis B*					
Varicella*					
Influenza					
Other (list)					

Serology Results					
Virus	**Date**	**Result**	**Virus**	**Date**	**Result**
Rubeola*			Varicella*		
Mumps*			HepBsAb*		
Rubella *			Other		

*Documentation of laboratory results is required - **You must submit a photocopy of each lab report.**

Name Health Care Provider (Print) Signature Date

Address City State/Country

Phone Number: Fax Number:

Unless otherwise noted, acceptable proof of immunization and/or immunity must be one or more of the following: Completion of the above by a health care provider with the provider's name, address, phone number and signature; a copy of a school or public health immunization record; a copy of a health care provider's record and official laboratory test evidence of protective serology.