FIU Herbert Wertheim College of Medicine
FLORIDA INTERNATIONAL UNIVERSITY

Immunization Documentation Form

Name: _____ Sex: Male ☐ Female ☐ Date of Birth _____/_____/_____

Email: _____ Day-time phone or cell: _____

Vaccine and Immunity Verification (*to be completed by health care provider):*

- ***For Hepatitis B & Varicella**: Copies of your actual lab test results indicating positive serum antibody titers are **required** as proof of immunity. When vaccine series is incomplete, the dates of vaccination should be provided on this form until the time when the serum antibody titers are done to prove vaccine-induced immunity.*

Vaccine / Test	Dates vaccine administered (month/day/year)			Attach required documents
MMR (Measles, Mumps, Rubella) *(2 MMR vaccine doses required after 12 months of age OR serologic documentation of IgG antibody titers for all three viruses)*	____/_____/____	____/_____/____		Antibody titer results and *date(s):* *Rubella:* _____ *Rubeola (Measles):* _____ *Mumps:* _____
Hepatitis B (primary series) *(3 dose vaccine series required AND serologic documentation of positive Hepatitis B surface antibody titer (IgG quantitative)*	____/____/____	____/____/____ *(1 month after first vaccine)*	____/____/____ *(6 months after first vaccine)*	Serologic titer result (*date*) ***REQUIRED***: Hepatitis B Surface Antibody titer (IgG quantitative) positive _____
Hepatitis B (second series) *(This series of three vaccines and antibody titer are required only if Hep B Surface antibody titer is negative after completing the first series)*	____/____/____	____/____/____ *(1 month after first vaccine)*	____/____/____ *(6 months after first vaccine)*	2nd titer result (*date*) ***REQUIRED***: Hepatitis B Surface Antibody titer (IgG quantitative) positive _____
Tetanus / Diphtheria / acellular Pertussis (Tdap)	____/_____/____ (*Provide documentation of Td (Tetanus/diphtheria)booster within last 2 years; if Td was received more than 2 years ago, then Tdap is required)*			*N/A*
Polio (*4 doses required **or** positive antibody titer)*	__/___/___	__/___/___	__/___/__	__/___/__ *Serologic titer required if dates of all 4 polio doses is not completed.* ***Titer result/date:*** _____
Varicella (Chicken Pox) *(positive Varicella serologic IgG titer required)* *(dates of Varicella vaccine – optional)*	____/_____/____	____/_____/____ *(1-2 months after first vaccine)*		Varicella IgG titer result and *date* ***REQUIRED*** _____
Meningitis (Meningococcal) *(one dose, strongly recommended)*	____/_____/____			*Waiver needs to be completed if vaccine is refused*
2-Step Tuberculosis Skin Test (PPD) *(chest x-ray required if PPD is +)*	____/_____/____	____/_____/____ *(to be done 1-2 weeks after first skin test)*		**If + PPD**: Need chest X-ray results within past 12 months and written clearance from MD (signature on TB Screening Form).

Physician Attestation Statement: *This section must be completed and signed.* **Based on the above immunization documentation, this student is cleared to participate in all aspects of a medical school education, including direct patient contact:**

☐ **Yes** ☐ **No** ☐ **Yes temporarily**, pending completion of the following recommendations pertaining to immunity status:

Recommendations (vaccines/ titers still needed with dates of required completion)**:** _____

_____

Physician's Signature: _____

Printed Name of Physician: _____ Date: _____

Office Phone: _____

Office Address: _____

OFFICE STAMP:

Upload this form to your American DataBank Complio online account.