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 quantitative titer done, attach results.
Mumps	• **2 Doses** #1 ____/____/____ #2 ____/____/____ • **or Quantitative Titer (attach results)** ____/____/____	• 2 MMRs or quantitative titer indicating immunity to each disease • If quantitative titer done, attach results.
Rubella (German Measles)	•**1 Dose** #1 ____/____/____ • **or Quantitative Titer (attach results)** ____/____/____	• 2 MMRs or quantitative titer indicating immunity to each disease • If quantitative titer done, attach results.
Varicella (Chicken Pox)	• **2 Doses** #1____/____/____ #2____/____/____ • **or Quantitative Titer (attach results)** ____/____/____	• 2 shot vaccination series OR quantitative titer indicating immunity • **Documentation of disease is not sufficient**
Tetanus and Diphtheria (Tdap)	**Tdap:** ____/____/____	• Evidence of a Tdap • Per Feb 2011 CDC Guidelines, Tdap may be administered regardless of last Td timing.
Tetanus (Td)	**Only Needed if More Recent Administration than Tdap** • **Td** ____/____/____	• Must have Td booster every 10 years.
TST (Tuberculin Skin Test) **Note: A reaction of 10mm or more is considered positive for healthcare workers**	**2 Step TST** (2 separate TST tests given 1 – 3 weeks apart) Test 1: __/__/__ , ___mm Results: ☐negative ☐ positive Test 2: __/__/__ , ___mm Results: ☐negative ☐ positive **If positive**, **attach chest x-ray report** Date ____/____/____ X-ray result: ☐ negative ☐ abnormal **If positive**, **attach MD treatment / prophylaxis statement** **If Quantiferon or TSpot Used – Attach Lab Results**	• 2 TSTs completed 1-3 weeks apart within the past 12 months • **If positive, provide written x-ray report, treatment statement from physician, and documentation of completed treatment if received**. **If quantiferon or TSpot testing used it must be within last 12 months.** • Separate 1 month from live vaccines
Hepatitis B →→→ →	• **3 Dose series** #1____/____/____ #2____/____/____ #3____/____/____ • **AND Quantitative Titer (Attach Results)** ___/___/__ • **If equivocal or negative titer, immediately restart series**	• 3 shot vaccination series over 6 months **AND** quantitative hepatitis B surface antibody titer indicating immunity. (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 _____ 1/14