2021-2022 Annual Immunization Review

University at Buffalo Student Health Services
Michael Hall, 3435 Main Street, Buffalo, NY 14214-8003
Phone: 716-829-3316 Fax: 716-829-2564

Circle your health-related program:

Athletic Training	**Nuclear Med**
Dental	**Nursing**
Exercise Science	**OT**
Medicine	**Pharmacy**
MedTech/BioTech	**PT**
Dietetic Intern	

This form is only for returning students enrolled in a health-related program (see list above). These students have already complied with New York State required immunization mandates for Measles, Mumps, and Rubella and Meningitis Education. That documentation is on record at UB Student Health Services. This form must be completed by a medical provider or Student Health Services *annually*. All sections must be completed. Submit completed form to Student Health Services via fax, mail, or in person.

Self-attestation must be completed by the student. **REQUIRED**	My signature below attests that, to the best of my knowledge, I am free from any physical or mental impairment which is of potential risk to patients/personnel or which might interfere with the performance of my duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or to other drugs or substances which may alter my behavior. _____ _____ Student Signature Date *If student cannot attest, an explanation letter signed by his/her medical/mental health provider must accompany this form.*

Immunization/ Vaccination	**Vaccine Date Month/Day/Year**			**Or Attach Serology (Titer) Results**
HEPATITIS B (month/day/year) For 1st year medical students the quantitative titer report is required. If Heplisav-B given, note this on the form. Only 2 doses are required.	#1	#2	#3	Or Positive Hepatitis B Titer **Must attach copy of lab report**
VARICELLA (month/day/year)	#1	#2	**Or** Date of clinician diagnosis	Or Positive Varicella Titer **Must attach copy of lab report**
TETANUS (month/day/year) Within 10 years. Complete both fields even if date is the same.	Date of most recent Tetanus and circle type: Circle: Td Tdap		Date of 1 lifetime, adult Tdap (pertussis booster):	
COVID-19 *Not Required* (may be a 1 or 2 dose series)	#1		#2	
	Circle: Moderna Pfizer Janssen AstraZeneca Other _____			
Tuberculosis test Within the last 12 months. PPD, QuantiFERON-TB Gold or T-Spot are acceptable. If test is contraindicated due to history of past positive result, you must provide date and measurement of the past positive test. Individuals with history of positive test must also complete fields marked with an *	PPD Date Placed: (Month/Day/Year)	PPD Date Read (Month/Day/Year) (Must be 48-72 hours after placement)	PPD Measurement: _____mm of induration	
	OR			
	QuantiFERON-TB Gold (QFT) or T-Spot Date (Month/Day/Year)		QFT or T-Spot Test Result: Positive Negative Equivocal Circle and attach lab report	
	If PPD results are ≥ 10mm or QFT or T-SPOT results are positive, a chest x-ray is REQUIRED.			
	*Chest X-Ray Date:		*Chest X-Ray Result:	
	***If positive PPD or positive TB lab result, did the student take INH or other TB medication(s)? YES NO** ***If yes, name & dose of medication(s): _____** ***Date Range of Treatment: _____ How many months did student take medication? _____(# of months)**			
	The following questions are mandatory for patients with history of positive TB test: *Have you had loss of appetite, or unexplained weight loss in the past year? YES NO *Have you had a persistent low-grade fever or night sweats over the past year? YES NO *Have you had a persistent, productive cough lasting 3 weeks or more, or have you coughed up blood at any point in the past year? YES NO *If patient answers yes to any of the above questions, refer to MD/DO/NP/PA for evaluation*			

Student's name (please print): _____ Birthdate: _____
Last First

UB Person #: _____ Expected grad. year: _____ Date form completed: _____

Medical provider signature/stamp: _____ Phone # of medical provider: _____