2025-2026 Annual Immunization Review

University at Buffalo Student Health Services
4350 Maple Road, Amherst, NY 14226
Phone: 716-829-3316 Fax: 716-829-2564

Form **ONLY for RETURNING STUDENTS** enrolled in a **HEALTH-RELATED PROGRAM** *(circle)*:

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

Name *(print)*: _____ **UB Person #:** _____
Last *First*

Birthdate: ____/____/____ **Expected Graduation Year:** _____
Month Day Year

- **Compliance with each immunization, tuberculosis testing, and the self-attestation is REQUIRED ANNUALLY**
  - *MMR and meningococcal information are UB admission requirements for all students. Documentation is already on file.*
- **All sections of this form must be reported to UB Student Health Services each year – YOU MAY EITHER:**
  - Schedule an appointment with Student Health for an in-person immunization review (form does *NOT* need to be completed)

OR

  - Have a licensed medical provider complete and sign the form. Submit via patient portal (patientportal.buffalo.edu), fax or mail.

SELF-ATTESTATION
- **Must be completed *each year VIA PATIENT PORTAL***
  - **patientportal.buffalo.edu**: Menu → Requirements → Annual Health-Related Attestation ("Update")
  - *If the student cannot attest, an explanation letter signed by the student's medical/mental health provider must accompany this form.*

Immunization	Submit dates in MM/DD/YYYY format
HEPATITIS B • **3-dose vaccine series required. List dates & brand of vaccine.** (*Heplisav-B meets requirement with* 2-dose series. *Recombivax-HB meets requirement with 2-dose series IF given between ages 11-15)* • Serology: In addition to vaccination, a positive **Hepatitis B Surface Antibody, Quantitative** Titer (blood test confirming immunity) is REQUIRED for all first-year medical students. Titer is *recommended* for students in other health-related programs.	Dose #1 ___/___/____ _____ Dose #2 ___/___/____ _____ Dose #3 ___/___/____ _____ Hepatitis B Surface AB, Quantitative*___/____/_____ ***MUST ATTACH LAB REPORT WITH REFERENCE RANGE***
TETANUS-DIPHTHERIA • Tetanus (Td/Tdap) booster within last 10 years • One lifetime adult **Tdap** *(contains pertussis)* is **required** • **Must complete both fields** even if the date is the same	Last Tetanus Booster Date____/____/_____ *Circle:* **Td** *or* **Tdap** ☐ ☐ Adult **Tdap** Vaccine Date____/____/_____ ***Document both fields above even if date is the same***
VARICELLA • Two doses of varicella vaccine; both administered after first birthday and at least 28 days apart **OR** • Medical provider/clinician documented history of varicella *(chickenpox) or herpes zoster (shingles) infection* **OR** • Serology (blood test): Positive varicella IgG antibody titer confirming immunity	Dose #1____/____/_____ Dose #2____/____/_____ **OR** Date of Medical Provider/Clinician Diagnosis___/_____/_____ **OR** Varicella Titer* Date____/_____/_____ ***MUST ATTACH LAB REPORT WITH REFERENCE RANGE***
INFLUENZA • One dose given annually during flu season. List date given & brand of vaccine.	____/____/_____ _____

Name *(print)*: _____ **UB Person #:** _____
Last *First*

TUBERCULOSIS (TB) TEST

- Must have been completed within the last 12 months *(unless history of positive TB test – see below)*
  - History of BCG vaccination does *not* exclude the student from this requirement
- PPD, QuantiFERON-TB Gold (QFT) *or* T-SPOT are acceptable
  - **MUST ATTACH LAB REPORT IF QFT OR T-SPOT IS COMPLETED**
- If PPD result is 10mm or more, or QFT or T-SPOT is positive, a chest x-ray is REQUIRED
- **History of positive TB test:**
  - Document date and result of test and chest x-ray
  - Complete Questions #1 and #2 below
  - TB testing does *not* need to be repeated. Chest x-ray should *only* be repeated *if "YES" to any symptoms* in Question #2.

PPD Date Placed: / /	PPD Date Read: / /	Induration/ Measurement (in mm):

OR

Circle test: ☐QFT or T-SPOT☐ ***MUST ATTACH LAB REPORT!**	Date of collection: / /	Circle Result: Negative☐ Positive☐	*An indeterminate, equivocal, borderline or invalid result is not acceptable. Repeat testing will be necessary.*

Chest x-ray REQUIRED IF: PPD ≥ 10mm *or* Positive QFT/T-SPOT

Chest X-Ray Date:	Chest X-Ray Result:

THE FOLLOWING RESPONSES REQUIRED ONLY IF HISTORY OF POSITIVE TB TEST

1. If negative chest x-ray and positive TB test, did the student complete a course of INH or other TB treatment? ☐**YES** ☐**NO**

a. If yes, name & dose of medication _____

b. Date range of treatment _____ Number of months of treatment _____

2. In the past year, has the patient experienced any of the following symptoms: unintended weight loss > 10 pounds, cough with sputum production > 3 weeks, bloody sputum, drenching night sweats, unexplained fever, fatigue > 3 weeks? ☐**YES** ☐**NO**

If "YES" to Question 2 above, patient must be evaluated by a medical provider to rule out active TB infection

Health Care Provider Signature | Date Form Completed

Health Care Provider Name (Print/Stamp) | Health Care Provider Address & Phone Number (Print/Stamp)