AMERICAN UNIVERSITY of ANTIGUA | COLLEGE OF MEDICINE

Immunization Record Form

PART 1: To be completed by the student		**Student ID#**	
Last Name:		First Name:	
Date of Birth (mm/dd/yyyy):		Term of Admission:	

PART 2: To be completed and signed by a health care provider.		**Date (mm/dd/yyyy)**	**Details / Titer* results and dates** *(Titers are mandatory)**
Tuberculosis Screening (PPD) *(Mandatory)*	Most recent PPD Date:		Quantiferon Gold Result Date:
	Result:		
	If positive (MM induration and date of +)		CXR Result Date:
Measles / Mumps / Rubella (MMR) *(Mandatory)*	MMR #1		Measles Titer: Date:
	MMR #2		Mumps Titer: Date:
	Any additional/booster MMR?		Rubella Titer: Date:
Tetanus and Diphtheria (DT or DPT) *Tetanus toxoid (TT) is not acceptable.* *(Mandatory)*	**a. Primary series complete? (At least three dose dates are required)**		
	Series 1 Series 4		
	Series 2 Series 5		
	Series 3 Series 6		
	b. Most recent booster? Date: (Must be within the last 10 years)		
	c. Exemption?		
	Attach physician's statement of medical contraindication with duration of medical condition or attach your personal statement of philosophical/religious objection to immunization.		
Varicella (Chicken Pox) *(Mandatory)*	Did you have disease? Fill in "x" [ ]YES [ ]NO		
	Varicella #1		Varicella Titer: Date:
	Varicella #2		
	Any additional/booster Varicella?		
Hepatitis B *(Mandatory)*	Hepatitis B #1		
	Hepatitis B #2		Hepatitis B Titer: Date:
	Hepatitis B #3		
	Any additional/booster Hep. B?		

Health care provider verifying information for Part 2

Physician Details	Name:	
	Signature:	Date (mm/dd/yyyy):
	Address:	

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FOR OFFICE USE ONLY
Date Received:

Complete: