Immunization Requirements for Entering Medical Students

A. All students must provide proof of completion of the *Hepatitis B* series of vaccine and serologic testing (titer) showing immunity to Hepatitis B. If Hepatitis B titer is negative, a Hep-B booster and new titer in 6 to 8 weeks is required.

B. Students born after 1956 must provide proof of immunization to *MMR* (Measles, Mumps, and Rubella) or are required to have serologic (titer) evidence of immunity to MMR.

C. All students must provide proof of a baseline *QFT* or *PPD Tuberculin* skin test.
   Students who test positive to PPD or have received the BCG vaccine, must provide results of a QFT blood test dated November 1 or later.

D. All students must provide proof of 2 Varicella vaccines or serologic (titer) evidence of immunity to Varicella.

E. All students must provide proof of a Tetanus (Td) booster within the past 10 years, and a one-time adult dose of Pertussis (Tdap).

F. All students will be required to receive an Influenza vaccination each "flu season" in accordance with CDC Healthcare Personnel recommendations.

G. All students are encouraged to be immunized with COVID-19 vaccines per the CDC recommendation.

All entering students must submit a 'Record of Required Immunizations' form signed by a healthcare provider. The documentation must include a record of all completed vaccinations or vaccinations that are in progress at the time of submission. Subsequently, documentation proof for missing immunizations must be provided as vaccination requirements are fulfilled.

Revised 10/2023
RECORD OF REQUIRED IMMUNIZATIONS
University of Michigan Medical School
1135 Catherine Street, SPC 5726 • Ann Arbor MI 48109-5726 • Phone (734) 936-3697

PART I - TO BE COMPLETED BY THE STUDENT

Name ____________________________
Last First MI ____________________________
Date of Birth: ____________________________
Street Address: ____________________________
City: ___________________ State: ____________ Zip: ____________
Phone: (___) ____________________________ Today's Date: ____________________________

PART II - TO BE COMPLETED AND SIGNED BY A LICENSED HEALTH CARE PROVIDER

A. Hepatitis B Vaccination
   1. …………………………………………………………………………………………… Month/Year ____________
   2. …………………………………………………………………………………………… Month/Year ____________
   3. …………………………………………………………………………………………… Month/Year ____________
   4. Results of Antibody Titer: (Required)
      Result…Positive/Immune ___ Negative/Non-Immune ___ Month/Year ____________
      • If Negative: Date of Hep-B Booster (Required) ……………………………. Month/Year ____________
      • New Titer: Result: Positive/Immune ___ Negative/Non-Immune ___ Month/Year ____________

B. Measles, Mumps, and Rubella
   1. 2 Doses of MMR Vaccine…………………………………………….. Month/Year ____________
      Or . . .
   2. Immune Titer (Required to be positive) ……………………………….. Month/Year ____________

C. Tuberculosis
   1. If PPD Negative dated November 1, 2022 or later …………………….. Month/Year ____________
   2. If PPD Positive, then QFT (Quantiferon Gold Test) dated November 1, 2022 or later
      QFT……. Positive ___ Negative ____________ Month/Year ____________
      • If QFT positive – refer for evaluation and possible treatment
      • If QFT negative – annual symptom review will be required
   3. EXCEPTION: Known exposure in past to BCG vaccine, then QFT dated November 1, 2022 or later is required ………….. Month/Year ____________

D. Varicella
   1. Two doses of Varicella Vaccine ……………………………………………….. Month/Year ____________
      Or . . .
   2. Immune Titer: (Required) Result……. Positive ___ Negative ____________ Month/Year ____________

E. Tetanus/Pertussis (Within past 10 years)
   1. Most recent Tetanus booster ……………………………………………….. Month/Year ____________
   2. One-time adult dose of Tdap (Required) …………………………………… Month/Year ____________

F. Influenza Vaccine: (Annual Requirement after matriculation to Medical School)
G. Optional - COVID-19 Vaccine: Dose 1: ______  Dose 2: ______ Booster Dose: ______

TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER

Name: ____________________________ Address: ____________________________
(Printed) Signature: ____________________________ Phone: ____________________________

Submit Document to: UMMS.Health.Records@umich.edu

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