University of Louisville
Immunization Compliance Form

Please complete this form, attach documentation, sign and return to your department program coordinator

Student / Employee ID #_____

Name: _____ Birth Date: ____/____/____
Last First Middle

Address: _____
Street City, State Zip Code

Day Telephone: (____) _____ Social Security Number: _____

School: ☐ Medicine ☐ Dentistry ☐ Nursing ☐ Resident Department:_____

Required Immunizations and Testing

Tetanus-Diphtheria Acellular Pertussis (Tdap) 1 Tdap dose is valid for ten years.	Tdap _____/_____/_____
Measles-Mumps-Rubella (MMR) Requirement: Measles 2 doses of vaccine or positive titer Mumps 2 doses of vaccine or positive titer Rubella 1 dose of vaccine or positive titer	MMR Dose 1: _____/_____/_____ MMR Dose 2: _____/_____/_____ OR Measles Titer: _____/_____/_____ Mumps Titer: _____/_____/_____ Rubella Titer: _____/_____/_____
Hepatitis B Vaccine (HepB) Requirement: 3 doses of vaccine followed by **QUANTITIVE** Hepatitis B Surface Antibody.	Hepatitis B Dose 1: _____/_____/_____ Hepatitis B Dose 2: _____/_____/_____ Hepatitis B Dose 3: _____/_____/_____ **AND** Hepatitis B Titer: _____/_____/_____
Varicella (Chickenpox) Vaccine 2 doses of vaccine or positive antibody titer.	Varicella Dose 1: _____/_____/_____ Varicella Dose 2: _____/_____/_____ **OR** Varicella Titer: _____/_____/_____
• **Tuberculosis Screening (PPD testing)** Requirements: one of the following **1. Current Staff/Students** a. Complete annual TB screening with TB skin or blood test if no history of positive reaction or treatment b. Complete annual TB questionnaire if previously positive **2. New Staff/Students to the University of Louisville** a. **Two** negative TST at least two weeks apart but not more than 12 months apart, regardless of BCG status. i. Results must be reported in millimeters of in duration. ii .TST testing is required annually once in compliance. iii. **Most recent TST must be completed within 60 days of starting your program or position.** b. If history of (+) TST or active Tuberculosis, provide documentation of treatment, if any and latest CXR report. c. Interferon Gamma Release (IGR) Assay for tuberculosis (Quantiferon TB-Gold, T-spot) in last 12 months.	PPD 1: _____/_____/_____ PPD 2: _____/_____/_____ **OR** CXR: _____/_____/_____ INH From: _____/_____/_____ TO _____/_____/_____ **OR** Quantiferon TB: _____/_____/_____

Please attach copies of all supporting documentation such as immunizations certificates, medical records, skin tests and laboratory reports.