

University of Minnesota Academic Health Center Tuberculosis & Immunization Form

The Academic Health Center requires that learners in an Academic Health Center (AHC) program meet all immunization requirements below.

- It may take up to 6 months to complete these requirements.
- This form must be completed, signed and dated by a health care provider and submitted via email to the Immunization Processing Office where it will become part of your official medical record.
- **Keep a copy** of this form and any other documentation for your personal immunization records.

ALL TUBERCULOSIS AND IMMUNIZATIONS BELOW (FRONT & BACK OF THIS FORM) MUST BE COMPLETED PRIOR TO ENROLLMENT

Last Name	First Name	Middle Name
Date of Birth (month/day/year)	Email Address	UMN ID Number
Street Address	City	State, ZIP Code
College or School (if medical resident, use "GME")		

Tuberculosis Screening: TB blood test (QuantiFERON TB-Gold or T-SPOT) OR TB skin tests are acceptable (<i>select one</i>)	
TB BLOOD TEST	Two-Step TST (Tuberculin Skin Test)
QuantiFERON or T-SPOT: Interferon Gamma Release Assay (IGRA) within the past 12 months Date of IGRA: _____ Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	<p>Two-Step TST: Report TWO TSTs applied more than one week apart and within 12 months of each other (<i>required once</i>).</p> <p>Date placed: _____ Date read: _____</p> <p>Result: _____ mm induration</p> <p>Interpretation: <input type="checkbox"/> Negative <input type="checkbox"/> Positive</p> <p>Date placed: _____ Date read: _____</p> <p>Result: _____ mm induration</p> <p>Interpretation: <input type="checkbox"/> Negative <input type="checkbox"/> Positive</p> <p>NOTE 1: If Two-Step TST was completed > 12 months ago, must also have Annual TST (see below).</p> <p>NOTE 2: TST may not be placed within 28 days of a live vaccination, such as a MMR, to be considered valid.</p> <p>NOTE 3: Must have baseline Two-Step TST prior to annual TST.</p>
	Annual TST: Report a TST completed within the past 12 months
	<p>Date placed: _____ Date read: _____</p> <p>Result: _____ mm induration</p> <p>Interpretation: <input type="checkbox"/> Negative <input type="checkbox"/> Positive</p>
CHEST X-RAY (REQUIRED ONCE For a <u>positive</u> QuantiFERON/IGRA or <u>positive</u> TST)	
Date of Chest X-ray (must be <i>after</i> date of positive TB test result): _____ Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	

Name: _____ UMN ID Number: _____

Required Immunizations		Dose Date month/day/year		Date of POSITIVE Titer
Measles, Mumps, Rubella (MMR) Document two doses after 12 months of age (minimum of 4 weeks between dose 1 and dose 2) OR Positive titer for each		___/___/___ Dose 1 MMR date	___/___/___ Dose 2 MMR date	___/___/___ Measles ___/___/___ Mumps ___/___/___ Rubella
If measles, mumps and rubella were received as individual vaccinations , document two doses for each, given at appropriate intervals OR Positive titer for each	Measles	___/___/___ Dose 1	___/___/___ Dose 2	___/___/___ Measles
	Mumps	___/___/___ Dose 1	___/___/___ Dose 2	___/___/___ Mumps
	Rubella	___/___/___ Dose 1	___/___/___ Dose 2	___/___/___ Rubella
Varicella Document two doses of vaccine (minimum of 4 weeks between dose 1 and dose 2) OR Positive titer OR Provider diagnosis of disease date		___/___/___ Dose 1	___/___/___ Dose 2	___/___/___ Varicella
		___/___/___ Disease date		
Tetanus/Diphtheria/Pertussis Tdap Document one dose received July 2005 or later.		___/___/___ Tdap		Titer is not required
<i>After 1 dose of Tdap, Td or Tdap is required every 10 years.</i>		___/___/___ Td		___/___/___ Tdap
Hepatitis B Document three doses of vaccine given at appropriate intervals OR Positive Hepatitis B Surface Antibody titer		___/___/___ Dose 1	___/___/___ Dose 2	___/___/___ Hepatitis B Surface Antibody
If you have completed the hepatitis B vaccine series and have a negative hepatitis B surface antibody titer, additional vaccination and re-testing for positive hepatitis B surface antibody titer is recommended.				

04/2018

To the best of my knowledge all the dates and immunizations listed on this form are accurate.

Provider's Signature: _____ Date: _____
 Physician, Nurse Practitioner, Physician's Assistant, RN, LPN, CMA

Provider's Name Printed: _____ Phone Number: _____

Clinic Address: _____

ASSISTANCE & INFORMATION

For questions regarding this form, please email immunizations@umn.edu or call 612-626-5571.

SUBMISSION INSTRUCTIONS

Email form to immunizations@umn.edu

To access your Tuberculosis and Immunization records, go to <https://boynton.umn.edu/myboynton>
Form processing may take 7-10 business days.