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 (*select one*)

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: ☐ **Negative** ☐ **Positive**	**Two-Step TST**: Report TWO TSTs applied more than one week apart and within 12 months of each other (***required once***). **Date placed**:___________ **Date read**:___________ **Result**:___________ mm induration Interpretation: ☐ **Negative** ☐ **Positive** **Date placed**:___________ **Date read**:___________ **Result**:___________ mm induration Interpretation: ☐ **Negative** ☐ **Positive** **NOTE 1**: If Two-Step TST was completed > 12 months ago, must also have **Annual TST** (see below). **NOTE 2**: TST may not be placed within 28 days of a live vaccination, such as a MMR, to be considered valid. **NOTE 3**: Must have baseline Two-Step TST prior to annual TST.
	Annual TST: Report a TST completed within the past 12 months
	Date placed:___________ **Date read**:___________ **Result**:___________ mm induration Interpretation: ☐ **Negative** ☐ **Positive**
CHEST X-RAY (REQUIRED ONCE For a positive QuantiFERON/IGRA or positive TST)	
Date of Chest X-ray (must be ***after*** date of positive TB test result):_____________ **Result**: ☐ Normal ☐ 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 __/__/__ Disease date	__/__/__ Varicella
Tetanus/Diphtheria/Pertussis Tdap Document one dose received July 2005 or later.		__/__/__ Tdap	Titer is not required
After 1 dose of Tdap, **Td** or **Tdap** is required every 10 years.		__/__/__ Td	__/__/__ Tdap
Hepatitis B Document three doses of vaccine given at appropriate intervals **OR** **Positive** Hepatitis B Surface Antibody titer		__/__/__ Dose 1 __/__/__ Dose 2 __/__/__ Dose 3	__/__/__ 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: ____

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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.

Boynton Health, Immunization Processing Office, 410 Church Street SE, Minneapolis, MN 55455
Phone: 612-626-5571 Fax: 612-626-9768