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

TB BLOOD TEST **OR** **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**

Baseline Two-Step TST is required *prior* to annual TSTs

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.

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 after 12 months of age (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 (**Engerix, Recombivax or Twinrix**) of vaccine or two doses of **Heplisav-B** given at appropriate intervals **OR** **Positive** Hepatitis B Surface Antibody titer		**Three-Dose Series** ___/___/___ ___/___/___ ___/___/___ Engerix, Recombivax, or Twinrix	**Two-Dose Series** ___/___/___ ___/___/___ Heplisav-B	___/___/___ 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.				

02/2020

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.