

University of Minnesota Academic Health Sciences Tuberculosis & Immunization Form

The Academic Health Sciences (AHS) colleges, schools and centers require that learners in an AHS 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 immunizations@umn.edu the Immunization Processing Office.
- **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: Baseline TB testing is required for all AHS learners. Annual testing is not required. Either a TB blood test (QuantIFERON TB-Gold or T-SPOT) **OR** a Two-Step TB skin test are acceptable.

TB BLOOD TEST	OR	Two-Step TST (Tuberculin Skin Test)
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QuantIFERON or T-SPOT: Interferon Gamma Release Assay (IGRA) within the past 12 months (*required once*)

Date of IGRA: _____

Result: Negative Positive

Two-Step TST*

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

***IMPORTANT:** If the Two-Step TST was completed > 12 months ago, you *must* provide documentation of a TST or IGRA performed within the past 12 months

Date placed: _____ Date read: _____

Result: _____ mm induration

NOTE: TST may not be placed within 28 days of a live vaccination, such as a MMR, to be considered valid.

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

Required Immunizations		Dose Date month/day/year		Date of POSITIVE Titer
<p>Measles, Mumps, Rubella (MMR) Document two doses after 12 months of age (minimum of 4 weeks between dose 1 and dose 2)</p> <p>OR Positive titer for each</p>		<p>____/____/____ ____/____/____ Dose 1 MMR date Dose 2 MMR date</p>		<p>____/____/____ Measles ____/____/____ Mumps ____/____/____ Rubella</p>
<p>If measles, mumps and rubella were received as individual vaccinations, document two doses for each, given at appropriate intervals</p> <p>OR Positive titer for each</p>	Measles	____/____/____	____/____/____	____/____/____ Measles
	Mumps	____/____/____	____/____/____	____/____/____ Mumps
	Rubella	____/____/____	____/____/____	____/____/____ Rubella
<p>Varicella Document two doses after 12 months of age (minimum of 4 weeks between dose 1 and dose 2)</p> <p>OR Positive titer</p>		<p>____/____/____ ____/____/____ Dose 1 Dose 2</p> <p>____/____/____ Disease date</p>		____/____/____ Varicella
<p>Tetanus/Diphtheria/Pertussis Tdap Document one dose received July 2005 or later.</p>		____/____/____ Tdap		Titer is not required
<p>After 1 dose of Tdap , either Td or Tdap is required every 10 years.</p>		____/____/____ or ____/____/____ Tdap Td		Titer is not required
<p>Hepatitis B Document three doses (Enerix, Recombivax or Twinrix) of vaccine or two doses of Heplisav-B given at appropriate intervals</p> <p>OR Positive Hepatitis B Surface Antibody titer</p>		<p>Three-Dose Series</p> <p>____/____/____ ____/____/____ ____/____/____</p> <p>Enerix, Recombivax, or Twinrix</p>	<p>Two-Dose Series</p> <p>____/____/____ ____/____/____</p> <p>Heplisav-B</p>	____/____/____ Hepatitis B Surface Antibody
<p>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.</p>				

06/2020

This form must be signed by a healthcare provider other than the AHS learner. Self-signature will not be accepted.

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

Provider's Signature: _____ Title: _____

Provider's Name Printed: _____ Date: _____

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 or Fax to 612-626-9768

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