**Tuberculosis, Vaccination and Titors Response Form**

**PART I: To be Filled Out by Student**

**Student Information**

<table>
<thead>
<tr>
<th>Student Name (First, Middle Initial, Last)</th>
<th>Date of Birth</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em><strong>/</strong></em>/____</td>
<td>☐ Male ☐ Female</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone Number</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ HOME ☐ CELL</td>
<td></td>
</tr>
</tbody>
</table>

**PART II: To be Filled Out by Provider**

**Screening for Tuberculosis**

Date PPD Planted: ____________________________

(must be within 1 year)

Date PPD Read: ____________________________

Result: __________ mm

Interpretation: Positive [ ] Negative [ ]

If Previously Positive:

Quantiferon Gold TB test Date: ____________________________

Result: __________ (please provide copy)

(must be within 6 months)

**OR**

Chest X-ray Date: ____________________________

Result: __________ (please provide copy)

(must be within 6 months)

**Vaccination and Titors History**

The following vaccines and laboratory tests are mandatory. Please attach the lab results showing the post immunization titters:

<table>
<thead>
<tr>
<th>MMR</th>
<th>Varicella</th>
<th>Hepatitis B</th>
<th>Tdap</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1.</td>
<td>1.</td>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
<td>2.</td>
<td>2.</td>
<td>3.</td>
</tr>
</tbody>
</table>

AND

AND

AND

**Dates**

**Titer (date/result)**

(complete & attach results showing immunity)

<table>
<thead>
<tr>
<th>Measles IgG</th>
<th>Varicella IgG</th>
<th>Hep B Surface Ab</th>
<th>No titers required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Must be within 10 yrs.*

Updated 11/23/15
The following vaccines are recommended. Please indicate vaccination date(s).

1. Hepatitis A Date(s): ______________ ______________
2. IPV Date(s): ______________
3. HPV Date(s): ______________ ______________ ______________

Please also send us any other vaccines you have received for travel.

1. Vaccine: ______________ Date(s): ______________
2. Vaccine: ______________ Date(s): ______________
3. Vaccine: ______________ Date(s): ______________

Provider Signature and Information

Provider Signature: ___________________________ Date: ___________________________

Provider Stamp:

Name:
Address:
Telephone #:
Email: