

School of Medicine  
Office of Medical Education

All vaccination records and lab reports should be attached to this worksheet, and all vaccination dates and results should also be filled out on this form. Form should be returned to Program Coordinator.

Last	First	Middle/Maiden	Birthdate
Program			EMPLID

**COVID 19** – COVID 19 vaccination or exemption is required. Please attach all relevant documentation.

**COVID 19 Vaccination**  
 Manufacturer: \_\_\_\_\_  
 #1 Date: \_\_\_\_\_  
 #2 Date: \_\_\_\_\_  
 (if required)

**AND**

**COVID Booster(s):** (if received)  
 Manufacturer: \_\_\_\_\_ Date: \_\_\_\_\_  
 Manufacturer: \_\_\_\_\_ Date: \_\_\_\_\_  
 Manufacturer: \_\_\_\_\_ Date: \_\_\_\_\_

**OR**

Not Vaccinated / Exemption

**Measles, Mumps & Rubella** – Proof of immunization by titers and documentation of 2 MMR vaccinations (after age 1) are required. If titers are low or negative, a booster is also required. If vaccine records are unavailable, the positive titers are sufficient

**MMR Vaccination**  
 #1 Date: \_\_\_\_\_  
 #2 Date: \_\_\_\_\_

**AND**

**Measles, Mumps & Rubella Titers:**  
 Measles Result: \_\_\_\_\_ Date: \_\_\_\_\_  
 Mumps Result: \_\_\_\_\_ Date: \_\_\_\_\_  
 Rubella Result: \_\_\_\_\_ Date: \_\_\_\_\_

**MMR Booster**  
 Date: \_\_\_\_\_

**Varicella** – Proof of immunization by titer or documentation of 2 vaccinations at least 4 weeks apart.

**Varicella Vaccination**  
 #1 Date: \_\_\_\_\_  
 #2 Date: \_\_\_\_\_

**OR**

**Varicella Titer:**  
 Result: \_\_\_\_\_ Date: \_\_\_\_\_

**Tetanus/Diphtheria with Pertussis** – Documentation of Tdap vaccination required. If Tdap vaccination was more than 10 years ago, documentation of TD less than 10 years ago is also required.

**Tdap Vaccination**  
 Date: \_\_\_\_\_

**AND**  
 If > 10 years ago

**Td Vaccination**  
 Date: \_\_\_\_\_

**Hepatitis B** – Documentation of 3 Hepatitis B vaccinations and Hepatitis B Surface AB Titer are required.

**Hepatitis B Vaccination**  
 #1 Date: \_\_\_\_\_  
 #2 Date: \_\_\_\_\_  
 #3 Date: \_\_\_\_\_

**AND**

**Hepatitis B Surface AB Titer:**  
 Result: \_\_\_\_\_ Date: \_\_\_\_\_

Attach Supporting Documentation Here:

Signature: \_\_\_\_\_