Immunization History Form

School of Nursing, PA Institute and Fones School of Dental Hygiene

This form must be completed by a licensed Physician, Nurse Practitioner or Physician Assistant

Student Last Name	Student First Name	UB ID#	Date of Birth: ____/____/____ Month Day Year
E-mail	Phone ( ) -	Sex Assigned at Birth	Gender Identity
Clinical Program (Choose One): ☐School of Nursing ☐PA Institute ☐Fones School of Dental Hygiene			

IMMUNIZATION HISTORY: Must be completed by Health Care Provider

All titer labs must be up to date within the last **3 years** to be accepted.

Lab results for titers **must be attached with submission** of the form.

Exemptions to vaccine requirements should be submitted using the appropriate form through Student Health Services.

MEASLES, MUMPS, RUBELLA (MMR) – Proof of vaccination AND evidence of immunity through titer required.

Titers required for All PA and Nursing Students	Measles, Mumps, Rubella (MMR) Vaccination • First dose must be given on or after your first birthday; second dose must be at least 28 days beyond first dose to be accepted. If no records available, complete titer documentation below.	Dose #1: ____/____/____ Month Day Year	Dose #2: ____/____/____ Month Day Year	Booster Dose: (if indicated): ____/____/____ Month Day Year
	Provide evidence of immunity to each individual disease through titer and attach lab results with submission. If not immune, contact Student Health Services for further guidance.	Measles: ❒ Immune Date ____/____/____ Month Day Year Mumps: ❒ Immune Date ____/____/____ Month Day Year Rubella: ❒ Immune Date ____/____/____ Month Day Year		

VARICELLA – Proof of vaccination or history of disease AND evidence of immunity through titer required.

Titers required for All PA and Nursing Students	Varicella Vaccination Proof • First dose must be given on or after your first birthday to be accepted		Dose #1: ____/____/____ Month Day Year	Dose #2: ____/____/____ Month Day Year
	In lieu of vaccination you may provide proof of history of disease. • Confirmation must include date of illness and initials by MD/DO/APRN/PA	Date of Disease ____/____/____ Month Day Year	Provider Initials _____	
	Provide evidence of immunity through titer and attach lab results with submission. If not immune, contact Student Health Services for further guidance.	Varicella: ❒ Immune Date ____/____/____ Month Day Year		

MENINGOCOCCAL– Vaccination required of all students living in university dormitories only.

Required for All Residential Students	Meningitis Vaccine (MCV 4) • Must cover strains A, C, Y, W-135 (Menactra, Menveo or MenQuadfi)	Dose #1: ____/____/____ Month Day Year	Dose #2: ____/____/____ Month Day Year
Required for All Non-Residential Students	Exemption to Meningococcal vaccine: ❒ I will not be living in university-owned dormitories ❒ I am over 23 years of age.		

HEPATITIS B – Proof of complete vaccination (3 doses) AND evidence of immunity by antibody titer required.

Required for All Students	Hepatitis B Vaccination Proof If no records available, complete titer documentation below.	Dose #1: ___/___/___ Month Day Year	Dose #2: ___/___/___ Month Day Year	Dose #3: ___/___/___ Month Day Year
	Provide evidence of immunity through titer and attach lab results with submission. If not immune, contact Student Health Services for further guidance.	Hep B: ❒ Immune Date ___/___/___ • Must be a Hep B surface antibody Month Day Year		
Required for PA students ONLY.	Provide documentation of Hepatitis B Surface antigen testing. • Required annually for 2nd and 3rd year PA students.	Date of Antigen Testing: ___/___/___ Month Day Year		

TETANUS-DIPTHERIA-PERTUSSIS– Proof of Tdap vaccination **within the past 10 years** required.

Required for All PA and Nursing Students	Tdap Vaccination Proof • After initial Tdap vaccine, Td or Tdap is an acceptable booster.	Most Recent Tdap: ___/___/___ Month Day Year

COVID-19– COVID-19 vaccination highly recommended for UB Nursing and PA Students. All students participating in the Nursing and PA programs are encouraged to remain up to date with current CDC Covid-19 Vaccination recommendations.

Highly Recommended for All PA and Nursing Students	If vaccinated, please provide documentation of date of vaccination and product name (example: 2024-2025 Moderna)	Dose #1: ___/___/___ Month Day Year Product Name:	Dose #2: ___/___/___ Month Day Year Product Name:	Booster: ___/___/___ Month Day Year Product Name:	Most Recent: ___/___/___ Month Day Year Product Name:
	If not vaccinated, please attest that you have no record of receiving the COVID-19 Vaccination. ❒ I have not received COVID-19 vaccination.				

TUBERCULOSIS (TB) Screening – Proof of IGRA testing **OR** Two-Step PPD required annually.

Required for All PA and Nursing Students	Option 1	Provide evidence of IGRA testing and attach lab results with submission. • Recommended if prior BCG vaccination.	Test: ❒ QuantiFERON ❒ T-Spot Results: ❒ Negative ❒ Positive Date ___/___/___ Month Day Year If positive, contact Student Health Services for further guidance.	
	Option 2	Provide evidence of a Two-Step PPD. If positive, contact Student Health Services for further guidance.	PPD #1 Planted: ___/___/___ Month Day Year Read: ___/___/___ Month Day Year Interpretation: ❒ Positive ❒ Negative	PPD #2 Planted: ___/___/___ Month Day Year Read: ___/___/___ Month Day Year Interpretation: ❒ Positive ❒ Negative

Influenza- Proof of influenza vaccination required annually.

Required for All PA and Nursing Students	Influenza Vaccination Proof • Must be updated annually by October 15th. • Attach evidence of flu vaccination with submission.	Most Recent Flu Vaccination: Lot #: ___/___/___ _____ Month Day Year

Physician/Health Care Provider's Information (Please print clearly):			
Last Name	First Name		Phone: ( ) -
Street	City	State	Zip Code
Health Care Provider's Signature and Credentials:			Date: ___/___/___ Month Day Year