Immunization History Form

School of Nursing and PA Institute

This form must be completed in its entirety by a licensed physician, physician assistant, or nurse practitioner annually for all nursing and PA students. For newly matriculating students, Health Form A, Sections **A, B** and **E** must be completed and submitted in conjunction with this form. Students must maintain a copy of the completed form for their records to be submitted to their program's clinical tracking system.

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	

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.

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.	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.

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 _____
	If no records available, complete titer documentation below.		
	Provide evidence of immunity to disease through titer and attach lab results with submission.	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 Nimenrix)	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 29 years of age.		

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

Required for All PA and Nursing 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 to disease through titer and attach lab results with submission. • Must be a Hep B surface antibody	Hep B: ❒ Immune Date ____/____/____ Month Day Year		
Required for PA students ONLY participating in clinicals in NY.	Provide documentation of Hepatitis B Surface antigen testing, attach lab results with submission to student health services. • 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 • Tdap only acceptable booster for recent dose.	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: _____	Other: ____/____/____ 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	
	Option 2	Provide evidence of a Two-Step PPD.	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: ____/____/____ 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			Date: ____/____/____ Month Day Year