Student Medical Record		
Name:		**Date of Birth:**
Mandatory Vaccines	**Date** (MM/DD/YYYY)	**Instructions**
Tetanus – Diphtheria (Td/Tdap)	Td: _ _/ _ _/ _ _ _ _ Tdap: _ _/ _ _/ _ _ _ _	Tdap **OR** Td dose done **within the last 10 years** is **required**
MMR (Measles, Mumps, Rubella) **OR** **Measles** titers **Mumps** titers **Rubella** titers	Dose 1: _ _/ _ _/ _ _ _ _ Dose 2: _ _/ _ _/ _ _ _ _ **OR** Positive titers: _ _/ _ _/ _ _ _ _ Positive titers: _ _/ _ _/ _ _ _ _ Positive titers: _ _/ _ _/ _ _ _ _	**2 doses** of **MMR vaccine** are **required** **OR** Date of measles, mumps and rubella **positive titers** with result of titers attached
Varicella vaccine **OR** **Varicella** titers	Dose 1: _/ _ _/ _ _ _ _ Dose 2: _ _/ _ _/ _ _ _ _ **OR** Positive titers: _ _/ _ _/ _ _ _ _	**2 doses** of **Varicella vaccine** are **required** **OR** Date of **positive titers** with result of titers attached
Tuberculosis Screening	**BCG:** _ _/ _ _/ _ _ _ _ (if done earlier) **TST (aka: PPD)** **Date placed**: _ _/ _ _/ _ _ _ _ **Date Read**: _ _/ _ _/ _ _ _ _ **Result:** _ _ (induration in mm) **OR** **TB QuantiFERON-IGRA date:** _ _/ _ _/ _ _ _ _ **Result:** _ _ _ _ _ _ _ _ _ _ _ _ **Chest X-Ray**: _ _/ _ _/ _ _ _ _ **Result:** __ Normal __ Abnormal (if induration > 10mm) **Treatment Received** (In case of positive TST) **Date started:** _ _/ _ _/ _ _ _ _ **Date ended:** _ _/ _ _/ _ _ _ _	**Tuberculosis Test OR TB QuantiFERON-IGRA must be done within the last 12 months** If **TST** Induration **> 10mm** or **TB QuantiFERON-IGRA** is **positive.** We require a **chest X-Ray** with attached **copy of the result.** If **positive TST** or **TB QuantiFERON-IGRA** obtained earlier, provide date and result of **Chest X-Ray** done. If **treatment** of Primary Tuberculosis received, **date and duration** of treatment must be provided.
Meningococcal Vaccine	**Date:** _ _/ _ _/ _ _ _ _	In case the student is going to stay at **AUB residency,** a dose of **Meningococcal vaccine after age 16** is **required**
Hepatitis B Vaccine **OR** **Anti HBs titers**	**Dose 1**: _ _/ _ _/ _ _ _ _ **Dose 2:** _ _/ _ _/ _ _ _ _ **Dose 3:** _ _/ _ _/ _ _ _ _ **OR** Positive titers: _ _/ _ _/ _ _ _ _	**3 doses** of **Hepatitis B vaccine** are **required** **OR** Date of **positive titers** with result of titers attached.
Optional Vaccines	**Date** (MM/DD/YYYY)	
Hepatitis A	**Dose 1**: _ _/ _ _/ _ _ _ _ **Dose 2:** _ _/ _ _/ _ _ _ _	
Human Papillomavirus Vaccine	**Dose 1**: _ _/ _ _/ _ _ _ _ **Dose 2:** _ _/ _ _/ _ _ _ _ **Dose 3:** _ _/ _ _/ _ _ _ _	

Physician's Contact Information:

Date of completing form: ______________________

Name: ______________________________

Phone Number: ______________________________

Signature: ___________________________

Email: ____

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