Rosalind Franklin University of Medicine and Science
The Chicago Medical School
Student Pre-matriculation Immunization Form

Name:	D.O. B _ _/_ _/_ _ _ _	Sex: M F	
Address:	City:	State:	Zip:

Infectious Disease History

	Yes	No		Yes	No		Yes	No
Rubeola			Varicella (Chickenpox)			Hepatitis A		
Mumps			Tuberculosis			Hepatitis B		
Rubella (German Measles)						Hepatitis C		

Immunization History

***Provider and Student: IgG Antibody titers are required for rubella, rubeola, varicella and Hepatitis B (once series has been completed). Please enter date and antibody results in the column provided. **Copies of ALL laboratory reports must be submitted.** For all other requirements, please enter immunization date(s) in the column provided.

	Immunization Date	Titer Date	Titer Result (Circle)
Tetanus/Diptheria (If last booster greater than 10 years ago, another booster is required)			
Mumps			
Rubella (German measles) Titer			+ / -
Rubeola (measles) Titer			+ / -
Varicella Titer			+ / -
If antibody titer is negative:			
Vaccine #1			
Vaccine #2			
Hepatitis B (series of 3 vaccines)			
Vaccine #1			
Vaccine #2			
Vaccine #3			
Hepatitis BsAb Titer			+ / -
Hepatitis A (optional)			
Vaccine #1			
Vaccine #2			
Meningococcal meningitis (recommended)			
Polio (minimum of 3 doses). If no documentation available titer or IPV booster needed.			
#1 _ _/_ _/_ _ _ _ #2 _ _/_ _/_ _ _ _ #3 _ _/_ _/_ _ _ _ #4 _ _/_ _/_ _ _ _ #5_ _/_ _/_ _ _ _			
Polio booster or titer (if needed)			+ / -
BCG (if applicable)			

Tuberculosis Skin Testing (PPD) Required within the 12 months prior to the start of classes. If student has had a positive PPD in the past, a chest x-ray is required within the 12 months prior to the start of classes. **A copy of the chest x-ray report must be submitted**.

	Date	Result	Induration
PPD Placement		+ / -	mm
If positive PPD:			
Chest X-ray		+ / -	

I certify that the above information is complete and correct to the best of my knowledge.

Signature of Healthcare Provider (MD, DO, PA, RN) _____ Printed Name _____ Date _____

The information provided in this questionnaire is accurate to the best of my knowledge. I understand and agree that any misrepresentation or omissions may be justification for denial of student privileges.

Student Signature _____ Printed Name _____ Date _____

Continuing Matriculation
RFUMS Office Use Only

Tuberculosis Skin Testing (PPD) Required every year. If student has had a positive PPD in the past, a chest x-ray is required to continue matriculating through classroom coursework. A copy of the chest x-ray report must be submitted.

	Date	Result	Induration
PPD Placement		+ / -	mm
If positive PPD:			
Chest X-ray		+ / -	

Tuberculosis Skin Testing (PPD) Required every year. If student has had a positive PPD in the past, a chest x-ray is required to continue matriculating through classroom coursework. A copy of the chest x-ray report must be submitted.

	Date	Result	Induration
PPD Placement		+ / -	mm
If positive PPD:			
Chest X-ray		+ / -	

Tuberculosis Skin Testing (PPD) Required every year. If student has had a positive PPD in the past, a chest x-ray is required to continue matriculating through classroom coursework. A copy of the chest x-ray report must be submitted.

	Date	Result	Induration
PPD Placement		+ / -	mm
If positive PPD:			
Chest X-ray		+ / -	

TB Mask Fit Testing

TB Mask Fit Testing completed date _____ Fit Tested with NIOSH # _____

Unable to fit test because _____

_____ _____
Entire form reviewed by Date

_____ _____
Entire form reviewed by Date

_____ _____
Entire form reviewed by Date

_____ _____
Entire form reviewed by Date