

**ROSALIND FRANKLIN UNIVERSITY OF MEDICINE AND SCIENCE**  
**STUDENT IMMUNIZATION FORM**

Date: \_\_\_\_\_ School: CMS \_\_\_\_\_ CHP \_\_\_\_\_ SCPM \_\_\_\_\_ SGPS \_\_\_\_\_  
 Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_  
 Current Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Pager \_\_\_\_\_ Email \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**INFECTIOUS DISEASE HISTORY**

	<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>
Rubeola (10-day measles)	<input type="radio"/>	<input type="radio"/>	Varicella (Chickenpox)	<input type="radio"/>	<input type="radio"/>	Hepatitis C	<input type="radio"/>	<input type="radio"/>
Mumps	<input type="radio"/>	<input type="radio"/>	Hepatitis A	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>
Rubella (German measles)	<input type="radio"/>	<input type="radio"/>	Hepatitis B	<input type="radio"/>	<input type="radio"/>			

**IMMUNIZATION HISTORY**

1. Student has been vaccinated against the following:		Immunization Date	Titer Date	Titer Result
	Tetanus/Diphtheria (within last 10 years)			
	Mumps			
+	Rubella (German measles)			Ab
+	Rubeola (measles)			Ab
* +	Varicella (Chickenpox)			Ab
+	Hepatitis B (3 step)			
	Vaccine #1			
	Vaccine #2			
	Vaccine #3			Ab
	Hepatitis A (optional)			Ab
	Meningococcal meningitis (recommended)			Ab
	Polio (minimum 3 doses); please provide dates of all doses:			
	#1            #2            #3            #4            #5			Ab
	BCG, if applicable (not acceptable in lieu of PPD)			
	Other			

\* Either immunization date(s) or titer date & laboratory report + Copies of laboratory titer results must be included

2. Tuberculosis Skin Test (PPD) required yearly.

\* NOTE: For students rotating at Stroger Hospital of Cook Co., two-step tuberculosis skin testing is required within 90 days prior to the clerkship start date.

	M1	M2	M3	M4
Date skin test given				
Date of negative reading				
Date of positive reading				
Induration	mm	mm	mm	mm

If TB skin test was positive, copy of PA Chest x-ray report must be included.

Chest x-ray	Date	neg	pos	Date	neg	pos
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\* VA Hospital requires CXR every year for positive PPD

\* Christ Hospital requires CXR every two years for positive PPD

