For incoming students who answered "YES" to any of the questions on the *Tuberculosis Risk Screening Questionnaire* on the Ashe Secure Portal

OR

If you are a Healthcare Professional Student (Medical/Dental/Nursing/Social Welfare) please complete section below:

<table>
<thead>
<tr>
<th>TUBERCULIN SKIN TEST (TST)</th>
<th>OR</th>
<th>TB BLOOD TEST (Recommended if history of BCG/TB Vaccine)</th>
</tr>
</thead>
<tbody>
<tr>
<td>One skin test required for NON-Healthcare Professional Students:</td>
<td></td>
<td>QUANTIFERON or T-SPOT (Interferon Gamma Release Assay – IGRA)</td>
</tr>
<tr>
<td>Date placed: ___________ Date read: ___________</td>
<td>Date placed: ___________ Date read: ___________</td>
<td>If not available, may do a Tuberculin Skin Test (TST) or Chest X-ray.</td>
</tr>
<tr>
<td>(must be read between 48-72hrs after it was placed)</td>
<td>(must be read between 48-72hrs after it was placed)</td>
<td>Date QTF/T-SPOT Test: __________________</td>
</tr>
<tr>
<td>Result: _ mm induration</td>
<td></td>
<td>Result: □ Negative □ Positive</td>
</tr>
<tr>
<td>Interpretation: □ Negative □ Positive</td>
<td></td>
<td>(IF POSITIVE, PROCEED TO SYMPTOMS &amp; BLOOD TEST OR CHEST X-RAY)</td>
</tr>
<tr>
<td>(IF POSITIVE, PROCEED TO SYMPTOMS &amp; BLOOD TEST OR CHEST X-RAY)</td>
<td>□ Indeterminate</td>
<td>(IF INDETERMINATE, REPEAT TEST OR PROCEED TO CHEST X-RAY)</td>
</tr>
<tr>
<td>Two skin tests required for Healthcare Professional Students:</td>
<td></td>
<td>SYMPTOMS:</td>
</tr>
<tr>
<td>Date placed: ___________ Date read: ___________</td>
<td>□ Cough for greater than 4wks □ Coughing up blood □ Unexplained Chest pain □ Persistent fever/chills/night □ Unexplained weight loss</td>
<td></td>
</tr>
<tr>
<td>(must be read between 48-72hrs after it was placed)</td>
<td></td>
<td>CHEST X-RAY (REQUIRED if TST or Quantiferon/IGRA +/or Symptoms are positive OR previous treatment for TB)</td>
</tr>
<tr>
<td>Result: _ mm induration</td>
<td>Date of Chest x-ray: _______________</td>
<td>Result: □ Normal □ Abnormal</td>
</tr>
<tr>
<td>Interpretation: □ Negative □ Positive</td>
<td>MUST ATTACH WRITTEN RADIOLOGY CHEST XRAY REPORT IN ENGLISH (DO NOT SEND FILMS/CD of actual X-ray)</td>
<td></td>
</tr>
<tr>
<td>(IF POSITIVE, PROCEED TO SYMPTOMS &amp; CHEST X-RAY)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Licensed Health Care Provider Name __________________ Signature __________________ Date _______________
### UNIVERSITY OF CALIFORNIA, LOS ANGELES IMMUNIZATION REQUIREMENTS

#### REQUIRED IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Required Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COVID-19</strong></td>
<td>PRIOR TO ENROLLING IN CLASSES: Must be up to date on COVID-19 vaccination: Up to date means you have received all CDC recommended COVID-19 vaccines, including any booster dose(s) when eligible.</td>
</tr>
<tr>
<td><strong>Annual Influenza vaccine</strong></td>
<td>MUST BE GIVEN AFTER AUGUST OF ENTERING YEAR</td>
</tr>
<tr>
<td><strong>Tdap Vaccine</strong></td>
<td>ONE DOSE ON OR AFTER AGE 7YRS FOR NON-Healthcare Professional Students - OR - ONE DOSE IN THE LAST 10YRS required for Healthcare Professional Students</td>
</tr>
<tr>
<td><strong>MMR Vaccine</strong></td>
<td>YOU MUST HAVE 2 DOSES. THE FIRST DOSE MUST BE ON OR AFTER YOUR FIRST BIRTHDAY.</td>
</tr>
<tr>
<td><strong>Varicella (Chicken Pox) Vaccine</strong></td>
<td>YOU MUST HAVE 2 DOSES. THE FIRST DOSE MUST BE ON OR AFTER YOUR FIRST BIRTHDAY.</td>
</tr>
</tbody>
</table>

#### Detailed Requirements

- **Tdap Vaccine**
  - Tetanus/Diphtheria WITH Pertussis (whooping cough)
  - *Please note: The requirement is Tdap and not Td or Dtap*
  - One dose on or after age 7YRS for Non-Healthcare Professional Students
  - One dose in the last 10YRS required for Healthcare Professional Students
  - **Dose Date:** __/__/__ (MM/DD/YR)

- **MMR Vaccine**
  - Measles, Mumps & Rubella
  - You must have 2 doses. The first dose must be on or after your first birthday.
    - **Dose 1 Date:** __/__/__ (must be on or after your 1st birthday)
    - (Dose 1 & 2 must be at least 28 days apart)
    - **Dose 2 Date:** __/__/__
  - If unable to obtain proof of vaccination, you must obtain a blood titer test.
  - **POSTIVE Measles IgG Antibody Titer**
    - Titer Date: __/__/__
  - **POSTIVE Mumps IgG Antibody Titer**
    - Titer Date: __/__/__
  - **POSTIVE Rubella IgG Antibody Titer**
    - Titer Date: __/__/__
    - If you have a negative or indeterminate titer, obtain one dose of MMR and repeat titer 4 weeks later. If titer is still negative, receive a 2nd dose of MMR.

- **Varicella (Chicken Pox) Vaccine**
  - You must have 2 doses. The first dose must be on or after your first birthday.
    - **Dose 1 Date:** __/__/__ (must be on or after your 1st birthday)
    - (Dose 1 & 2 must be at least 28 days apart)
    - **Dose 2 Date:** __/__/__
  - If you had the disease as a child or if you are unable to obtain proof of vaccination, you must obtain a blood titer test.
  - **POSTIVE Varicella IgG Antibody Titer**
    - Titer Date: __/__/__
    - If you have a negative or indeterminate titer, obtain one dose of varicella vaccine and repeat titer 4 weeks later. If titer is still negative, receive a 2nd dose of varicella.
### Meningococcal Vaccine
- MCV4 (Menactra or Menveo preferred) for students 21 yrs or younger

**THE MOST RECENT DOSE MUST BE ON OR AFTER YOUR 16TH BIRTHDAY.**

Dose Date: ______/ ___/____ (MM/DD/YR)

### ADDITIONAL REQUIREMENTS FOR ALL HEALTHCARE PROFESSIONAL SCHOOL STUDENTS (MEDICAL/NURSING/DENTAL/SOCIAL WELFARE)

#### Hepatitis B Immunity
All students must have a series of three Hepatitis B vaccinations (initial dose, dose two at 1 month, and dose three at 6 months). A post-vaccine surface antibody titer (to demonstrate immunity) is required one month after 3rd vaccine dose.

| Dose #1   |   /   (MM/DD/YR) |
| Dose #2   |   /   (MM/DD/YR) |
| Dose #3   |   /   (MM/DD/YR) |

**Hep B surface antibody titer:**
- Reactive: ☐
- Non-Reactive: ☐
- Date: ______/___/_____

*If antibody non-reactive, Hepatitis B surface antigen is required prior to repeat series.*

**Hep B surface antigen titer:**
- Reactive: ☐
- Non-Reactive: ☐
- Date: ______/___/_____

If Hep B surface antigen is negative, get Hepatitis B vaccine booster. Repeat titer one month later.

| Dose #4   |   /   (MM/DD/YR) |
| 2nd Hep B surface antibody titer: Reactive: ☐
- Non-Reactive: ☐
- Date: ______/___/_____

*If repeat Hep B surface antibody is non-reactive, continue with 2nd series and then check titer one month later.*

| Dose #5   |   /   (MM/DD/YR) | Dose #6   |   /   (MM/DD/YR) |
| 3rd Hep B surface antibody titer: Reactive: ☐
- Non-Reactive: ☐
- Date: ______/___/_____

*If repeat Hep B surface antibody is non-reactive, please schedule with an Ashe Center clinician to discuss.*

### STRONGLY RECOMMENDED IMMUNIZATIONS

**NOTE: These vaccinations are recommended BUT NOT required to be compliant with enrollment**

#### HPV Vaccine
- Human Papilloma Virus Vaccine
- 3 dose series

**RECOMMENDED FOR ALL STUDENTS (ALL GENDERS) UP TO THE AGE OF 26**

**HPV 4**
- Dose 1 Date: _____________
- Dose 2 Date: _____________
- Dose 3 Date: _____________

**OR**

**HPV 9**
- Dose 1 Date: _____________
- Dose 2 Date: _____________
- Dose 3 Date: _____________

#### Meningococcal B Vaccine
- Trumemba or Bexsero

**RECOMMENDED FOR AGES 16 – 23YRS AFTER DISCUSSION WITH A HEALTHCARE PROVIDER**

Dose 1 Date: _____________
Dose 2 Date: _____________
(Trumemba is either a 2 dose or 3 dose series. Bexsero is a 2 dose series)
Dose 3 Date: _____________
<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>Series Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A Vaccine</td>
<td>2 dose series &lt;br&gt;<strong>Dose 1 Date:</strong> &lt;br&gt;<strong>(Dose 2 must be at LEAST 6 mths following first)</strong> &lt;br&gt;<strong>Dose 2 Date:</strong> _______</td>
</tr>
<tr>
<td>Polio Vaccine</td>
<td>4 dose series &lt;br&gt;<strong>Dose 1 Date:</strong> _______ &lt;br&gt;<strong>Dose 2 Date:</strong> _______ &lt;br&gt;<strong>Dose 3 Date:</strong> _______ &lt;br&gt;<strong>Dose 4 Date:</strong> _______</td>
</tr>
<tr>
<td>Pneumococcal Vaccine</td>
<td>PCV13 +/- or PPSV23 based on health history &lt;br&gt;<strong>Dose PCV13 Date:</strong> _______ &lt;br&gt;<strong>Dose PPSV23 Date:</strong> _______ &lt;br&gt;<strong>Only recommended for those with a history of asthma, diabetes, smokers and those with immunosuppression due to illness or medication after discussion with your healthcare provider</strong></td>
</tr>
</tbody>
</table>

**I ATTEST THAT ALL DATES AND IMMUNIZATIONS LISTED ON THIS FORM ARE CORRECT AND ACCURATE**

Provider’s Signature: ___________________________ Practice Stamp: ___________________________

Provider’s Name: ___________________________ Date: _______

(Physician/PA/NP/RN)