UCLA Immunization Requirements

Student ID:	Date of Birth (mm/dd/yy):	Name (first last):

This form must be signed by a healthcare provider attesting all information is true and accurate OR student may supply all required source documents.

REQUIRED VACCINATIONS FOR ALL STUDENTS						
Vaccination	**Titer Result Date**	**Titer Result**	**If not immune, 2 doses of vaccine**		**Date received**	**Vaccine received**
Measles		☐ Immune ☐ Non-Immune ☐ Equivocal	**OR**	X 2	(Dose 1 must be on or after age one)	
Mumps		☐ Immune ☐ Non-Immune ☐ Equivocal	**OR**	X 2	(Dose 1 must be on or after age one)	
Rubella		☐ Immune ☐ Non-Immune ☐ Equivocal	**OR**	X 2	(Dose 1 must be on or after age one)	
Varicella		☐ Immune ☐ Non-Immune ☐ Equivocal	**OR**	X 2	(Dose 1 must be on or after age one)	
Tdap (Note: Td, DTaP, Dtap do not satisfy the requirement)		**NON-Healthcare Professional Students** ONE DOSE ON OR AFTER AGE 11				☐ Adacel ☐ Boostrix ☐ _____
		Healthcare Professional Students (DGSOM, Dental, Nursing, Social Welfare) ONE DOSE IN THE LAST 10 YEARS				☐ Adacel ☐ Boostrix ☐ _____

Vaccination	Date received	Manufacturer	Lot #		Declination
COVID-19 vaccination	(Dose must be updated 2025-2026 COVID-19 vaccine)	☐ Pfizer ☐ Moderna ☐ Novavax		OR	☐ I am voluntarily choosing to decline the COVID-19 vaccine.
Seasonal Influenza	(Dose must be on or after August 1, of entering year)				☐ I am voluntarily choosing to decline the seasonal influenza vaccine.

AND

REQUIRED ONLY FOR STUDENTS UNDER THE AGE OF 22			
Meningococcal Vaccine (MenACWY)	Date received	ACWY Vaccine Received	
THE MOST RECENT DOSE MUST BE *ON OR AFTER AGE 16* Note: MenB vaccine does not meet the requirement		☐ Menactra ☐ Menveo ☐ MenQuadfi ☐ _____	

<table>
<tr><td colspan="6">ADDITIONAL REQUIREMENTS FOR ALL HEALTHCARE PROFESSIONAL SCHOOL STUDENTS (DGSOM/NURSING/DENTAL/SOCIAL WELFARE)</td></tr>
<tr><td>Hepatitis B Immunity</td><td>Date (MM/DD/YY)</td><td>HbsAb Titer</td><td>If HbsAb non-reactive, or no vaccine documented, must vaccinate</td><td>Date (MM/DD/YY)</td><td>Vaccine received</td></tr>
<tr><td rowspan="3">Hepatitis B Surface Ab Titer (HbsAb) Anti-HBs</td><td rowspan="3"></td><td rowspan="3">☐ Reactive
☐ Non-Reactive</td><td rowspan="3">3 dose series (Engerix-B or Recombivax)

Or
2 dose series (Heplisav-B)</td><td></td><td>☐ Engerix-B
☐ Recombivax
☐ Heplisav-B</td></tr>
<tr><td></td><td>☐ Engerix-B
☐ Recombivax
☐ Heplisav-B</td></tr>
<tr><td></td><td>☐ Engerix-B
☐ Recombivax
☐ Heplisav-B</td></tr>
<tr><td colspan="6">If HbsAb non-reactive, Hepatitis B surface antigen is required prior to repeat series.</td></tr>
<tr><td></td><td>Date (MM/DD/YY)</td><td>HbsAg Titer</td><td colspan="3" rowspan="2"></td></tr>
<tr><td>Hepatitis B Surface Ag Titer (HbsAg)</td><td></td><td>☐ Reactive
☐ Non-Reactive</td></tr>
<tr><td colspan="6">If Hep B surface antigen is non-reactive, get Hepatitis B vaccine booster. Repeat HbsAb Titer one month later.</td></tr>
<tr><td></td><td>Date (MM/DD/YY)</td><td>Vaccine received</td><td colspan="3" rowspan="3"></td></tr>
<tr><td>Hepatitis B vaccine booster</td><td></td><td>☐ Engerix-B
☐ Recombivax
OR
☐ Heplisav-B</td></tr>
<tr><td>Second Hep B surface antibody titer</td><td>Date (MM/DD/YY)</td><td>☐ Reactive
☐ Non-Reactive</td></tr>
<tr><td colspan="6">If the second Hep B surface antibody is non-reactive, complete second series. Repeat HbsAb Titer one month later.</td></tr>
<tr><td></td><td>Date (MM/DD/YY)</td><td>Vaccine received</td><td colspan="3" rowspan="4"></td></tr>
<tr><td rowspan="2">Hepatitis B vaccine</td><td></td><td>☐ Engerix-B
☐ Recombivax
OR
☐ Heplisav-B</td></tr>
<tr><td></td><td>☐ Engerix-B
☐ Recombivax</td></tr>
<tr><td>Third Hep B surface antibody titer</td><td>Date (MM/DD/YY)</td><td>☐ Reactive
☐ Non-Reactive</td></tr>
<tr><td colspan="6">*If third Hep B surface antibody is non-reactive, please schedule with an Ashe Center clinician to discuss.</td></tr>
</table>

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

Provider's Signature: _____

Provider's Name (MD/DO/NP/RN): _____

Date: _____

Practice Stamp (or address/phone):

TUBERCULOSIS (TB) HEALTH ASSESSMENT FORM:

Required for Healthcare Professional Students (DGSOM/Dental/Nursing/Social Welfare) and incoming students who answered "YES" to any of the questions on the Tuberculosis Risk Screening Questionnaire on the Ashe Secure Portal.

I have a history of a positive TB Skin Test, T-Spot or Quantiferon Blood Test (circle one): ☐ No ☐ Yes. If "yes" Date: _____

TUBERCULOSIS SYMPTOM REVIEW – Check all appropriate boxes	
Cough lasting more than 3 weeks: ☐ No ☐ Yes	Excessive sputum: ☐ No ☐ Yes
Coughing up blood: ☐ No ☐ Yes	Excessive fatigue/malaise: ☐ No ☐ Yes
Unexplained/unintended weight loss (> 5lbs): ☐ No ☐ Yes	Recent unprotected close contact with a person with active TB: ☐ No ☐ Yes
Night sweats (not related to menopause): ☐ No ☐ Yes	History of immune dysfunction or are you receiving chemotherapeutic or immunosuppressant agents: ☐ No ☐ Yes
Fever/chills: ☐ No ☐ Yes	Allergies: ☐ No known Allergies ☐ Yes:
**If you have any of the above symptoms, meet with your provider to determine whether a chest x-ray is indicated.*	

TUBERCULOSIS TESTING (date of test must be within the 6-month period preceding entry to UCLA)				
Tuberculin Skin Test (*option for NON-Healthcare Professional Students only*)	Date placed: (MM/DD/YYYY)	Date read: (MM/DD/YYYY)	Result (mm induration):	Interpretation: ☐ Negative ☐ Positive*
OR				
Quantiferon or T-spot (Interferon Gamma Release Assay – IGRA) ***Required for Healthcare Professional Students or students with a history of BCG Vaccine.***	Date of test: (MM/DD/YYYY)	Name of test: ☐ Quantiferon ☐ T-Spot	Result: ☐ Negative ☐ Positive* ☐ Indeterminate If indeterminate, repeat test in one month or obtain chest x-ray	[redacted]
Chest X-Ray ***(*Required if TBST or IGRA are positive; previous treatment for TB; or if "yes" answers to symptoms)***	Date of chest x-ray (MM/DD/YYYY)		Result: ☐ Negative ☐ Abnormal Must attach written radiology chest x-ray report in English (DO NOT SEND FILMS/CD of actual x-ray)	
If Chest X-Ray is positive for active Tuberculosis, please contact the Ashe Center: asheimmune@ashe.ucla.edu				

I ATTEST THAT ALL INFORMATION LISTED ON THIS TUBERCULOSIS HEALTH ASSESSMENT FORM ARE CORRECT AND ACCURATE.

Provider's Signature: _____

Provider's Name (MD/DO/NP/RN): _____

Date: _____

Practice Stamp (or address/phone):

FORM UPDATED 06/2025