2024-2025 Annual Immunization Review

University at Buffalo Student Health Services
4350 Maple Road, Amherst, NY 14226
Phone: 716-829-3316 Fax: 716-829-2564

Form **ONLY for RETURNING STUDENTS** enrolled in a **HEALTH-RELATED PROGRAM** *(circle)*:

Athletic Training	**Exercise Science**	**Nursing**
Communicative Disorders	**Medicine**	**OT**
Dental	**MedTech/BioTech**	**Pharmacy**
Dietetic Intern	**Nuclear Medicine**	**PT**

Name *(print)*: ______________________________________ **UB Person #:** ____________________
Last *First*

Birthdate:_____/______/______ **Expected Graduation Year:** __________
Month Day Year

- **Compliance with each immunization, tuberculosis testing, and the self-attestation is REQUIRED ANNUALLY**
  - *MMR and Meningococcal information are UB admission requirements for all students. Documentation is already on file.*
- **All sections of this form must be reported to UB Student Health Services each year – YOU MAY EITHER:**
  - Schedule an appointment with Student Health for an in-person immunization review (form does *NOT* need to be completed)

    OR
  - Have a licensed medical provider complete and sign the form. Submit via patient portal (patientportal.buffalo.edu), fax or mail.

SELF-ATTESTATION

- **Must be completed *each year VIA PATIENT PORTAL***
  - **patientportal.buffalo.edu**: Menu → Requirements & Forms → Annual Health-Related Attestation ("Update")
  - *If the student cannot attest, an explanation letter signed by the student's medical/mental health provider must accompany this form.*

Immunization	Submit dates in MM/DD/YYYY format
HEPATITIS B • Three dose series (*Heplisav-B only requires two doses)* **OR** • Serology (blood test): Positive Hepatitis B Surface Antibody, **Quantitative** Titer confirming immunity ***Serology REQUIRED for all first-year medical students***	Dose #1____/____/____ *Circle if Heplisav-B* Dose #2____/____/____ *Circle if Heplisav-B* Dose #3_/_/_ **OR** Hepatitis B Titer Date_/_/_____ *****MUST ATTACH QUANTITATIVE LAB REPORT WITH REFERENCE RANGE*****
TETANUS-DIPHTHERIA • Tetanus (Td/Tdap) booster within last 10 years • One lifetime adult **Tdap** *(contains pertussis)* is **required** • **Must complete both fields** even if the date is the same	Last Tetanus Booster Date_____/____/_____ *Circle:* **Td** *or* **Tdap** Adult **Tdap** Vaccine Date_____/____/_____ *****DATES REQUIRED FOR BOTH*****
VARICELLA • Two doses of varicella vaccine; both administered after first birthday and at least 28 days apart **OR** • Medical provider/clinician documented history of varicella *(chickenpox)* disease **OR** • Serology (blood test): Positive varicella IgG antibody titer confirming immunity	Dose #1_____/____/_____ Dose #2_____/____/_____ **OR** Medical Provider/Clinician Diagnosis_____/____/_____ **OR** Varicella Titer Date_____/_____/_____ *****MUST ATTACH LAB REPORT WITH REFERENCE RANGE*****
INFLUENZA • One seasonal dose given annually. List most recent dose. Include brand name on the line next to the dose date.	____/_____/_____ ________________________

Name *(print)*:______________________________ **UB Person #:** ______________________
Last *First*

TUBERCULOSIS (TB) TEST

- Must have been completed within the last 12 months *(unless history of positive TB test – see below)*
  - History of BCG vaccination does *not* exclude the student from this requirement
- PPD, QuantiFERON-TB Gold (QFT) *or* T-SPOT are acceptable
  - **MUST ATTACH LAB REPORT IF QFT OR T-SPOT IS COMPLETED**
- If PPD result is 10mm or more, or QFT or T-SPOT is positive, a chest x-ray is REQUIRED
- **History of positive TB test:**
  - Document date and result of test and chest x-ray
  - Complete Questions #1 and #2 below
  - TB testing does *not* need to be repeated. Chest x-ray should *only* be repeated *if "YES" to any symptoms* in Question #2.

PPD Date Placed:	PPD Date Read:	Induration/ Measurement (in mm):
	OR	
QFT *or* T-Spot Collected Date:	QFT or T-Spot Result *(circle)*: ****MUST ATTACH LAB REPORT****	Positive Negative Equivocal

****Chest x-ray REQUIRED IF: PPD ≥ 10mm *or* Positive QFT/T-SPOT****

Chest X-Ray Date:	Chest X-Ray Result:

RESPONSES REQUIRED ONLY IF HISTORY OF POSITIVE TB TEST

1. If negative chest x-ray and positive TB test, did the student complete a course of INH or other TB treatment? **YES** **NO**
   a. If yes, name & dose of medication______________________________
   b. Date range of treatment____________________Number of months of treatment______________

2. In the past year, have you experienced any of the following symptoms: unintended weight loss > 10 pounds, cough with sputum production > 3 weeks, bloody sputum, drenching night sweats, unexplained fever, fatigue > 3 weeks? **YES** **NO**

*****If "YES" to any symptoms, you must be evaluated by a medical provider, which must include the date and results of a recent chest x-ray.*****

____
Health Care Provider Signature Date Form Completed

____
Health Care Provider Name (Print/Stamp) Health Care Provider Address & Phone Number (Print/Stamp)