WAKE FOREST UNIVERSITY SCHOOL OF MEDICINE
EMPLOYEE/STUDENT HEALTH SERVICE
IMMUNIZATION REQUIREMENTS FOR VISITING STUDENTS

Name _____ ☐ Medical ☐ Campbell Pharmacy

Birthdate _____ ☐ AHEC ☐ Medical Sonics

There are no exceptions for meeting requirements with this symbol (*) except for medical contraindications or religious objections, which must be in writing.

1. *Tetanus-Pertussis-Diphtheria series . . . . . ____/____/____ , ____/____/____, ____/____/____
   *Tetanus-Diphtheria booster < 10 years old . . . . . ____/____/____
   *TDAP. . . . . ____/____/____

2. *Either A or B must be completed.
   A. *Measles/Mumps/Rubella (MMR) – TWO DOSES after 12 months of age and after 4/22/71 . . . . . .
      (1) ____/____/____ & (2) ____/____/____

OR

B1. *Measles (Rubeola) – one option must be met:
   a. ☐ **TWO** doses after 12 months of age and after 3/21/73 . . . . .____/____/____ & ____/____/____
   b. ☐ Blood titer proving immunity . . . . . .Date of test: ____/____/____
      TEST RESULT_____

B2. *Mumps
   a. ☐ **TWO** doses after 12 months of age and after 12/28/67 . . . . . .____/____/____ & ____/____/____
   b. ☐ Blood titer proving immunity . . . . . .Date of test: ____/____/____
      TEST RESULT_____

B3. *Rubella (German Measles) – one option must be met:
   a. ☐ Immunization after 12 months of age and after 6/9/69 . . . . . .____/____/____
   b. ☐ Blood titer proving immunity . . . . . Date of test: ____/____/____
      TEST RESULT_____

3. *Varicella (Chickenpox or Shingles) Titer – **Blood test required** even with past history of disease or vaccination
   (Medical/religious objection not applicable).
   Result of test: (Circle one) Positive Negative Date of Test: ____/____/____
   (If negative, must provide proof of at least ONE vaccine dose received)

4. *TB Test must be PPD Test < 12 months before date of arrival (Tine test not accepted).

   Date of Test: ____/____/____ Test Date Read: ____/____/____ Result of Test: _____mm induration

   If last or any previous test was positive, state type and dates of treatment, and result and date of latest x-ray:

   _____

5. *Student must either sign and attach statement of declination or get Hepatitis B series
   Hepatitis B Vaccine . . . . . (1) ____/____/____, (2) ____/____/____ & (3) ____/____/____
   Hepatitis B Antibody Test
   Result of test: (Circle one) Positive Negative Date of Test: ____/____/____

I hereby certify that the above student meets ALL requirements of Wake Forest University.

_____ _____ _____
Name of School Health Official Title Date

_____ _____
School Address

EMPLOYEE HEALTH SERVICES REVIEW:_____