

VISITING MED STUDENT



Student ID Number

PLEASE PRINT LARGE

Last Name First Name

Social Security Number Sex Date of Birth (month/day/year)

Place of Birth

Local Address Apt # Zip Code

Local/Cell Phone Number Email Address

Marital Status Mother's Maiden Name

Emergency Contact Name Relationship ( ) Phone Number

Insurance Name Insurance Address

Insurance Policy Insurance Group Number Policy Holder's Name

Signature Date

\*\*\*\*\* STAFF ONLY\*\*\*\*\*

COORDINATORS'S INITIALS

# Visiting Medical Students - Immunization Requirements



**Questions** regarding immunization requirements or immunization form?  
Please contact Keeya Bailey at [keeya.bailey@uchospitals.edu](mailto:keeya.bailey@uchospitals.edu)  
during business hours.

## The attached immunization form must be:

1. Completed **in English** by a Health Care Provider.
2. The immunization form must be returned to the **Pritzker School of Medicine**.
3. Do not send original immunization booklets/documents – make a copy & complete attached form.
4. Immunizations forms will only be accepted **mailed or hand-delivered**.

## Mailing Address:

Pritzker School of Medicine  
c/o Visiting Student Coordinator  
924 E. 57<sup>th</sup> St., Suite 104 BSLC  
Chicago, IL 60637

## INSTRUCTIONS. PLEASE READ CAREFULLY:

- HEALTH CARE PROVIDER:** A licensed provider healthcare provider is: a physician licensed to practice medicine in all of its branches (M.D. or D.O.), a Licensed Nurse, or a Public Health Official.
- ENGLISH:** All immunization forms and copies of laboratory reports **must be submitted in English**. Translations of non-English documents **must be certified**. It is acceptable to have an English translation of the documents certified as accurate by a member of the University community who is fluent in the document's original language.
- MEASLES, MUMPS, RUBELLA:** A copy of laboratory report(s) in English with evidence of immunity to Measles, Mumps, and Rubella. Students whose laboratory testing does not indicate immunity should receive additional immunizations as appropriate and record these dates.
- HEPATITIS B:** Students should submit a copy of a laboratory report(s) in English of a blood test (Hepatitis B surface Antibody) to demonstrate immunity. Students whose laboratory testing does not indicate immunity should receive additional immunizations as appropriate and record these dates.
- VARICELLA:** Students who have previously had Varicella infection (chicken pox) should have their immunity verified with a blood titer and submit a copy of laboratory report(s) in English. Students who have not previously been infected or whose laboratory testing does not indicate immunity should complete the two-dose vaccination series. Vaccines should be given at least 30 days apart.
- TETANUS/PERTUSSIS:** All students must show proof of vaccination for Tetanus, Diphtheria and Pertussis within the past ten years. Proof of immunity may be submitted by forwarding a copy of childhood immunization records, or a recent dose of Tdap. For students who currently require vaccination, the Tdap (tetanus, diphtheria and acellular pertussis) vaccine is needed to satisfy the pertussis requirement.
- TUBERCULOSIS SCREENING:** Screening for tuberculosis exposure is a skin test performed within the last 12 months. Students with a previous history of a positive tuberculosis skin test must submit a chest X-ray report obtained within 12 months of entry. They should not have skin testing completed.
- RESPIRATOR MASK FIT TESTING:** Students must provide certificate of training and fitting of a respirator mask. Testing may be performed at Student Care Center PRIOR to start date.
- INTERNATIONAL STUDENTS:** **Must provide three (3) dose dates for Tetanus/diphtheria vaccinations.** The 1<sup>st</sup> and 2<sup>nd</sup> doses must be separated by a minimum of 28 days. The 2<sup>nd</sup> and 3<sup>rd</sup> doses must be separated by a minimum of 6 months. **One dose must be a Tdap and given within the last ten (10) years.**
- EXEMPTIONS:** Anyone with a vaccine exemption may be excluded from the University/College in the event of a Measles, Mumps, Rubella or Diphtheria outbreak in accordance with public health law.
  - **MEDICAL CONTRAINDICATIONS:** a written, signed, and dated statement from a physician stating the vaccine that is contraindicated, the nature, and duration of the medical condition that contraindicates the vaccine(s). This statement will not be accepted if it does not meet the standards of care at The University of Chicago Hospitals. Submit this statement with application to the Pritzker School of Medicine.
  - **PREGNANCY OR SUSPECTED PREGNANCY:** a signed statement from a physician stating the student is pregnant or pregnancy is suspected. Pregnancy exemptions are applicable only to Measles, Mumps, Rubella and Varicella vaccination requirements. Submit this statement with application to the Pritzker School of Medicine.
  - **RELIGIOUS EXEMPTION:** a written, signed, and dated statement by the student detailing the student's objection to immunization on religious grounds. Request for religious exemptions will be forwarded for review and **only** be granted by the Registrar. Submit this statement with application to the Pritzker School of Medicine.

# The University of Chicago Visiting Medical Student Immunization Record

## PART I- To be completed by the student.

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle name: \_\_\_\_\_

Date of birth (MM/DD/Year) \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell Telephone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

## PART II - To be completed and signed by Health Care Provider(s). A health care provider is a physician licensed to practice medicine in all of its branches (M.D. or D.O.), a Licensed Nurse, or a Public Health Official. Please read the enclosed instructions. **All dates must include MONTH and YEAR.**

<p><b>MEASLES</b> (Must attach a copy of laboratory test in English.)</p>	<p>Date of blood titer. ____/____/____ Result: _____</p>
<p><b>RUBELLA (German Measles)</b> (Must attach a copy of laboratory test in English.)</p>	<p>Date of blood titer. ____/____/____ Result: _____</p>
<p><b>MUMPS</b> (Must attach a copy of laboratory test in English.)</p>	<p>Date of blood titer. ____/____/____ Result: _____</p>
<p><b>HEPATITIS B</b> (Vaccine schedule as approved by the CDC: Three total doses given at 0, 1-2, and 4-6 months) <b><u>Step 1-Vaccine Series</u></b></p> <p>1. ____/____/____ 2. ____/____/____ 3. ____/____/____</p> <p>*Vaccine schedule must be started before entry.</p>	<p><b><u>Step 2-Proof of Immunity</u></b></p> <p>Date of blood titer ____/____/____ (Hepatitis B Surface Antibody) Result: _____ (Must attach a copy of laboratory test in English.)</p>
<p><b>VARICELLA ZOSTER/CHICKEN POX</b> (Must attach a copy of laboratory test in English)</p>	<p>Date of blood titer. ____/____/____ (Varicella Zoster Antibody) Result: _____</p> <p style="text-align: center;"><b>or</b></p> <p>Dates of immunization if you have not had chicken pox. (Two doses separated by at least 30 days are required)</p> <p>1. ____/____/____ 2. ____/____/____</p>

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Date of birth (MM/DD/YEAR) \_\_\_\_\_

**TETANUS/DIPHThERIA/PERTUSSIS: Complete Section 1 only for international students.**  
**Complete Section 2 only for US citizens or permanent residents.**

SECTION 1: International Students	Identify immunization given:	SECTION 2: U.S. Citizens or permanent residents	
a. First immunization	a. Date of immunization _____ / _____ / _____ Td <b>or</b> Tdap	Date of most recent tetanus booster. (Given within past 10 years)	Date of immunization _____ / _____ / _____ <b>Identify immunization given:</b> Td <b>OR</b> Tdap
b. Second immunization (Given at least 28 days after first immunization).	b. Date of immunization _____ / _____ / _____ Td <b>or</b> Tdap		
c. Third immunization/ tetanus booster. Given at least 6 months after second immunization & within the past 10 years.	c. Date of immunization _____ / _____ / _____ Td <b>or</b> Tdap		

**TUBERCULOSIS SCREENING**

<p><b>Tuberculin skin test (Mantoux only)</b></p> <p>Completed within 12 months of entry. Dates must include month, date, and year. Result must be recorded in millimeters of induration. If no induration, record 0.</p> <p style="text-align: center;"><b>Or</b></p> <p>If the student has a history of a positive TB skin test or treated TB disease, a chest X-ray done in the USA within 1 year of registration is required. <b>Must attach chest X-ray report.</b></p>	<p>Date of placement _____ / _____ / _____</p> <p>Date read _____ / _____ / _____</p> <p>Result: _____ mm induration</p> <p style="text-align: center;"><b>Or</b></p> <p>Date of Chest X-ray _____ / _____ / _____</p>
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**PART III-Health Care Provider Certification must be signed.**

Provider(s) signature \_\_\_\_\_

Provider printed name(s) \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

**PART IV-Office use only.**

	Measles	G. Measles	Mumps	Tet/Dip	Hepatitis	Varicella
Immune						
Exempt						
Outstanding						

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

# FAQ's

Here are some of the most *Frequently Asked Questions* for Visiting Medical Students:

**Q: Can I just submit my immunization records in place of the Health Immunization Form?**

A: The Health Immunization Form is a required document. Please make certain that you have the form specifically for **Visiting Medical Students**. This form must be completed and signed by a licensed healthcare provider.

**Q: Why isn't my immunization history sufficient for proof of immunity?**

A: The University of Chicago adheres to the guidelines of the American Association of Medical Colleges (AAMC) and, the Center for Disease Control (CDC) and Prevention for healthcare workers. Proof of immunity must be verified via blood titers for Measles, Mumps, Rubella, Varicella and Hepatitis B. Immunity for Tetanus and Pertussis are verifiable by a recent dose of Diphtheria Tetanus Acellular Pertussis (DTAP) vaccine.

**Q: If I need blood titers, why should I submit my immunization history?**

A: Immunization dates are important in the event that your blood titers are negative. Each required titer has a specific number of doses needed to complete a series. For example, Illinois requires the following: either 2 doses of MMR *or* 2 doses of Measles, 1 dose of Mumps and 1 dose of Rubella. It is also important to note that the first dose of MMR is not given before 12 months of age, your 1<sup>st</sup> birthday.

If a titer is negative for any of the required, specific guidelines are available for attempting to boost one's immunity. In most cases, an additional dose of the vaccine will be administered and the titer rechecked after 30 days, if it is not medically contraindicated.

**Q: What if I had the Varicella infection (chickenpox) as a child?**

A: In most cases, your titer will prove immunity if you had the infection in the past. Otherwise you will be required to complete a 2 dose series for Varicella.

**Q: I started the Hepatitis B series but never completed it. Do I need to start the series over?**

A: Generally, we don't restart the series. The most common approach would be to give the missing dose-wait 30 days, then get a Hepatitis B Surface Antibody drawn.

**Q: I had a PPD (TB skin test) last year. Do I need another one?**

A: All Medical Students are required to get annual PPD testing. Your last PPD must have been within the last year-not to expire while visiting U of C.

**Q: What if I have had a positive PPD in the past?**

A: You must attach a copy of a Chest X-ray with your health form. Please note that receiving the BCG vaccine does not always presents a positive reaction. Therefore, a Chest X-ray is only acceptable for positive PPD reactions (greater than 10mm).

**Q: What is a Respirator Mask Fit Test?**

A: A special training for the proper application of masks to be worn while caring for respiratory compromised patients. Check with your schools health service-it's possible that it was done in your 1<sup>st</sup> year of Medical School.

**Q: Why does UC require so much?**

A: All Medical Colleges require the same. It is our intent to maintain healthcare and provide knowledge of communicable diseases within the profession you have chosen. It is important in healthcare to KNOW YOUR STATUS.

*Have any other questions????? Email [Keeya.Bailey@uchospitals.edu](mailto:Keeya.Bailey@uchospitals.edu)*