INDIANA UNIVERSITY SCHOOL OF MEDICINE

VSAS APPLICATION SUPPORTING DOCUMENT: PLEASE PRINT, VERIFY, SIGN AND UPLOAD WITH HIPAA DOCUMENTATION BELOW.

Guest Student Required Immunizations Form

It is imperative that you have certain immunizations completed prior to your participation in our Guest Student Senior Elective Program because of the direct patient contact you will encounter during your professional training. The appropriate information should be properly recorded by your physician, or by your School. You may use the immunization sheet provided or a signed copy of your school record. ***If using your school record, please highlight and identify required information.***

1. **TETANUS AND DIPHTHERIA** - All students must be immunized. (Must be with the last 10 years.)

2. **RUBELLA** - All students are required to have either a **RUBELLA TITRE** or receive **RUBELLA VACCINE**. (the current standard at Indiana University School of Medicine is that rubella immunizations is required if the titre indicates susceptibility - lack of detectable antibody.)

3. **RUBEOLA** (Measles) - All persons born after 1957 who have not had physician diagnosed measles (rubeola) must show evidence of inoculation with live virus measles vaccine on or after their first birthday or show laboratory evidence of immunity. If measles vaccine was received before 1968 and the type of vaccine is unknown, evidence of vaccination after 1968 must be shown or immunity proven by laboratory testing.

4. **MUMPS** - Male students are required to be immunized if there is no definite knowledge of having had the disease.

5. **POLIOMYELITIS** - If you have NOT previously been immunized for POLIO, please discuss this with your physician and proceed according to this instructions. Inactivated (Salk) vaccine is recommended for adult immunization.

6. **TUBERCULOSIS - ALL STUDENTS MUST HAVE A PPD TUBERCULIN SKIN TEST WITHIN THE LAST YEAR.** If you have a newly positive reaction to the skin test, a chest x-ray is required and the results recorded on the immunization sheet. Your physician should indicate what treatment, if any, has been prescribed for you as a result of a positive skin test or chest x-ray.

7. **HEPATITIS B IMMUNIZATION** - is required. Because of your contact with patients you will be at increased risk for acquiring hepatitis B compared to an individual not working in a health related field. Hepatitis B may be prevented by immunization with the hepatitis B vaccine. This vaccine is effective for preventing infection and experience acquired in the several years since its widespread use has indicated that it is safe and well tolerated. Each student is encouraged to ask his physician all questions pertaining to the indications, effectiveness and safety of the vaccine

NAME_____

DATE OF BIRTH_____

REQUIRED IMMUNIZATIONS AND TESTS

TB SKIN TEST (PPD) Date_____Results: Pos_____Neg_____
(UPDATE REQUIRED IF THIS TEST IS MORE THAN ONE YEAR OLD AT START OF ELECTIVE. PLEASE DO NOT TURN IN AN OUT OF DATE TEST AS THIS WILL SLOW THE PROCESS)

Chest Film (**If Positive**) Date_____

Treatment Prescribed (if any)_____

TETANUS/DIPHTHERIA: Date of Last Booster:_____
(BOOSTER WITHIN LAST 10 YEARS – DO NOT TURN IN AN OUT OF DATE TEST)

RUBELLA:
Date and Titre Reading:_____

Date of Vaccine if Needed:_____

MUMPS: Date of Vaccine if Given:_____

MEASLES: Date Vaccine Given:_____

POLIO VACCINE: Date of Series:
OPV or IPV_____

Completed Salk_____

HEPATITIS B: Date Vaccine Given:_____

INFLUENZA VACCINATION
(Must be within last year)_____

***PHYSICIAN SIGNATURE**:_____ **DATE**: _____
*May also be signed by school official.