UNIVERSITY OF CALIFORNIA DAVIS IMMUNIZATION REQUIREMENTS

Please have your Primary Care Provider/Doctors office complete this information BEFORE entering your details online. This form is to be used as a guide for the information required for your online submission. These immunizations OR proof of positive titers are required BEFORE enrollment/registration to UCD (you may also be able to access this information on your Electronic Medical Record, Yellow Immunization Card or other immunization record).

_____ _____ _____

Date of Birth Name Student ID

REQUIRED IMMUNIZATIONS	To be compliant with enrollment these immunizations MUST BE complete prior to enrollment/registration.
Tdap (tetanus, diphtheria, pertussis) **One (1) after age 7 and then tetanus booster (Td) or Tdap every 10 years after initial Tdap**	Initial Tdap Date._____/_____/_____ Most recent Tdap (or Td) Date _____/_____/_____
MMR (Measles (Rubeola), Mumps, Rubella) **(1st dose on or after the 1st birthday)**	Dose 1 Date_____/_____/_____ Dose 2 Date_____/_____/_____ **OR** **If unable to obtain proof of vaccination, positive titer will fulfill requirement:** **POSITIVE Measles IgG Antibody titer** Titer Date_____/_____/_____ **POSITIVE Mumps IgG Antibody titer** Titer Date_____/_____/_____ **POSITIVE Rubella IgG Antibody titer** Titer Date_____/_____/_____ *If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer 4-6 weeks post vaccination. If titer is still negative, receive a second dose of vaccine and repeat titer 4-6 weeks later. Vaccine doses must be at least 28 days apart.
Varicella (chicken pox) **(1st dose on or after the 1st birthday)**	Dose 1 Date _____/_____/_____ Dose 2 Date_____/_____/_____ OR **If unable to obtain proof of vaccination, positive titer will fulfill requirement:** **POSITIVE Varicella IgG Antibody titer** Titer Date_____/_____/_____ *If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer 4-6 weeks post vaccination. If titer is still negative, receive a second dose of vaccine and repeat titer 4-6 weeks later. Vaccine doses must be at least 28 days apart.
Meningococcal Conjugate (MCV4) (1 dose on or after age 16 for all students age 21 yrs or younger)	Dose Date_____/_____/_____
STRONGLY RECOMMENDED IMMUNIZATIONS	**These vaccinations are recommended BUT NOT required to be compliant with enrollment/registration.**
Human Papilloma Virus Vaccine (HPV**) Recommended for all students up to the age of 26.**	Dose 1 Date_____/_____/_____ Dose 2 Date_____/_____/_____ Dose 3 Date_____/_____/_____

Hepatitis B	Dose 1 Date_____/_____/_____ Dose 2 Date_____/_____/_____ Dose 3 Date_____/_____/_____ **POSITIVE Hepatitis B IgG Antibody titer** Titer Date_____/_____/_____ *****If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer 4-6 weeks post vaccination. If titer is still negative, receive a second dose of vaccine and repeat titer 4-6 weeks later. Vaccine doses must be at least 28 days apart.
Meningococcal Conjugate (MCV4) (One dose up to age 23 based on health and lifestyle risk factors)	Dose Date_____/_____/_____
Meningococcal B (Bexsero or Trumenba) for ages 16-23 who elect vaccination after discussion with their healthcare provider.	**3 doses required for Trumenba or 2 doses required for Bexsero.** Dose 1 Date_____/_____/_____ Dose 2 Date_____/_____/_____ Dose 3 Date_____/_____/_____
Hepatitis A	**Two doses are recommended.** Dose 1 Date_____/_____/_____ Dose 2 Date_____/_____/_____
Polio	Dose 1 Date_____/_____/_____ Dose 2 Date_____/_____/_____ Dose 3 Date_____/_____/_____ Dose 4 Date_____/_____/_____ Dose 5 Date_____/_____/_____
Pneumococcal (PSV13 and/or PPSV23 based on health and other risk factors)	**Pneumococcal vaccine is recommended for those with a history of immunosuppression (HIV, diabetes), respiratory disease (asthma) and for all those who smoke cigarettes or E-cigs.** Dose 1 Date_____/_____/_____
Tuberculosis	Please complete the TB Screening Questions on Health-e-Messaging**.** If, based on the TB questions, you will be notified by Health-e-Messaging if you are at higher risk for TB and given further instructions.

I attest that all dates and immunizations listed on this form are correct and accurate.

Provider's Signature _____Date_____

Provider's name _____Phone number_____
(Physician/NP/PA/RN)

Log onto Health-E-Messaging and follow instructions to upload this completed form and to enter your immunizations.