UCDAVIS
STUDENT HEALTH AND COUNSELING SERVICES

UNIVERSITY OF CALIFORNIA DAVIS IMMUNIZATION REQUIREMENTS

Please have your Primary Care Provider/Doctor's office complete this information **BEFORE** entering your details online. This form is a guide for the information required for your online submission. You may also be able to access this information on your Electronic Medical Record, Yellow Immunization Card, California Digital Vaccine Record online, or other immunization record. These immunizations OR proof of positive titers are required **BEFORE** enrollment/registration to UCD.

Date of Birth (MM/DD/YYY) _____ Name _____ Student ID _____

REQUIRED IMMUNIZATIONS (affect registration hold)	To be compliant with these immunizations MUST BE complete prior to enrollment/registration.
MMR (Measles [Rubeola], Mumps, Rubella) **Two (2) doses with first dose on or after 1st birthday** OR **Positive titer** (laboratory evidence of disease immunity)	Dose 1 Date ____/____/____ (MM / DD / YYYY) Dose 2 Date ____/____/____ (MM / DD / YYYY) OR **If unable to obtain proof of vaccination, positive titer will fulfill requirement:** **POSITIVE Measles (Rubeola) IgG Antibody titer** Titer Date____/____/____ **POSITIVE Mumps IgG Antibody titer** Titer Date____/____/____ **POSITIVE Rubella IgG Antibody titer** Titer Date____/____/____ *If you have a negative, equivocal 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 (Chickenpox) **Two (2) doses with first dose on or after 1st birthday** OR **Positive titer** (laboratory evidence of disease immunity) (NOTE: History of contracting the disease does **NOT** meet compliance)	Dose 1 Date ____/____/____ (MM / DD / YYYY) Dose 2 Date ____/____/____ (MM / DD / YYYY) 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, equivocal 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.
TdaP (Tetanus, Diphtheria, Pertussis) **Vaccine must contain pertussis** **One (1) TdaP dose on or after the 11th birthday, then Tdap or Td every 10 years.**	Most Recent Dose Date____/____/____ (MM / DD / YYYY)
Meningococcal Conjugate (Serogroups A, C, Y, & W-135) **One (1) dose on or after age 16 for all students age 21 years or younger** OR **Two (2) doses of pentavalent, 6 months apart**	Name of Vaccine _____ Menveo, MenQuadFi, or Menomune: Dose Date ____/____/____ (MM / DD / YYYY) Penbraya: Dose 1 Date ____/____/____ (MM / DD / YYYY) Dose 2 Date ____/____/____ (MM / DD / YYYY)
Tuberculosis (TB) Screening	Please complete the **TB Screening Questions** on Health-e-Messaging. If you are at higher risk for tuberculosis (TB), you will be notified by Health-e-Messaging and given further instructions. Additional action and testing MAY be required. Please be sure to check your Health e-Messaging and UC Davis email for updates from Student Health.

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)

Office Stamp or License #

Date of Birth (MM/DD/YYY) _____ Name _____ Student ID _____

Immunizations Required by Policy (does not affect registration)	These vaccinations are required by policy, but can be formally declined through Health-e-Messaging if not received.
Influenza (Flu) All students regardless of age are required to receive or affirmatively decline influenza vaccination annually	Also see flu policy: https://ucnet.universityofcalifornia.edu/news/2021/10/2021-22-flu-vaccination-executive-order.pdf Dose Date____/____/____ MM / DD / YYYY
COVID-19 All students regardless of age are required to be Up-to-Date or affirmatively decline COVID-19 vaccination	Also see COVID-19 policy: https://policy.ucop.edu/doc/5000695/VaccinationProgramsPolicy Dose Date____/____/____ MM / DD / YYYY

Optional, but Recommended (does not affect registration)	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 and other ages who elect vaccination after discussion with their healthcare provider.	Dose 1 Date ____/____/____ (MM / DD / YYYY) Dose 2 Date ____/____/____ (MM / DD / YYYY) Dose 3 Date ____/____/____ (MM / DD / YYYY)
Hepatitis B All students regardless of age	Dose 1 Date ____/____/____ (MM / DD / YYYY) Dose 2 Date ____/____/____ (MM / DD / YYYY) Dose 3 Date ____/____/____ (MM / DD / YYYY) OR **POSITIVE Hepatitis B IgG Antibody titer** Titer Date____/____/____ *If you have a negative, equivocal 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	Name of Vaccine _____ Dose Date____/____/____ MM / DD / YYYY
Meningococcal B (Bexsero or Trumenba) OR **Meningococcal Pentavalent** (Penbraya) for ages 16-23 who elect vaccination after discussion with their healthcare provider.	Name of Vaccine _____ Dose 1 Date ____/____/____ (MM / DD / YYYY) Dose 2 Date ____/____/____ (MM / DD / YYYY) **2 doses required for Bexsero or Penbraya** Dose 3 Date ____/____/____ (MM / DD / YYYY) **3 doses required for Trumenba**
Hepatitis A All students regardless of age	Dose 1 Date ____/____/____ (MM / DD / YYYY) Dose 2 Date ____/____/____ (MM / DD / YYYY) **Two doses are recommended.**
Polio Regardless of age, if the series was not completed as a child	Dose 1 Date ____/____/____ (MM / DD / YYYY) Dose 2 Date ____/____/____ (MM / DD / YYYY) Dose 3 Date ____/____/____ (MM / DD / YYYY) Dose 4 Date ____/____/____ (MM / DD / YYYY) Dose 5 Date ____/____/____ (MM / DD / YYYY)
Pneumococcal For students with certain medical conditions including immunosuppression, diabetes, respiratory/lung disease, and/or risk factors such as smoking	Type of Vaccine _____ Dose Date____/____/____ MM / DD / YYYY

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)

Office Stamp or License #

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