

# Visiting Student Immunization Information

## Loyola University Chicago Stritch School of Medicine

All immunization paperwork must be uploaded to your application when you first apply for a rotation. We will not review any applications that do not have the required immunization documentation.

### Our Immunization Requirements

Loyola University Stritch School of Medicine requires students to show proof of surveillance for **tuberculosis** infection **within 12 months** of their scheduled clinical rotation and proof of immunization against **Measles, Mumps, Rubella, Varicella, Hepatitis B, and Tetanus, Diphtheria & Pertussis (TDAP vaccine)**. **Laboratory titers must be provided for Measles, Mumps, Rubella, Varicella, and Hepatitis B. Proof of annual influenza immunization required for rotations between November 1 and April 30.** A health care professional must verify all information on this form and date and sign it in the space provided at the bottom.

### Checklist for students

<u>Included?</u>	<u>Proof of Immunizations</u>
	Measles (Rubeola) titer
	Mumps titer
	Rubella titer
	Varicella titer
	Hepatitis B titer
	TDAP (Tetanus, Diphtheria, Pertussis) vaccine
	Tuberculosis screening (within 12 months of requested rotation) --any of the following are acceptable to fulfill the TB screening: A negative 2 step PPD*, Quantiferon Gold, Tspot, or x-ray report.  *The second PPD test must be at least one week after the first PPD and no later than 12 months after the first PPD.
	Seasonal flu vaccine (once available, for rotations between Nov 1 and April 30)

Any missing immunization requirements (as determined by our Student Health nurse) must be met no later than **two weeks prior** to the beginning date of the elective. **Any questions may be directed to the Student Health Service at 708-216-2458.**

# Visiting Student Immunization Information

## Loyola University Chicago Stritch School of Medicine

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

School: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Email: \_\_\_\_\_

Potential Rotation Dates: \_\_\_\_\_

### Immunization Requirements

Measles (Rubeola) IGG AB      Serology Date: _____ Attach copy of immune titer results.	German Measles (Rubella) IGG AB      Serology Date: _____ Attach copy of immune titer results.
Mumps IGG AB      Serology Date: _____ Attach copy of immune titer results.	Chickenpox (Varicella) IGG AB      Serology Date: _____ Attach copy of immune titer results.
Hepatitis B Surface Antibody      Serology Date: _____ Attach copy of immune titer results.	
TDAP (Tetanus, Diphtheria, Pertussis)      Dose Date: _____ <i>Vaccine date must be within last 10 yrs.</i>	

### TB Screening Requirement *(Must be within 12 mo. of rotation dates)*

2 Step Tuberculosis Skin Test (PPD)	PPD 1 Date Placed: _____ PPD 2 Date Placed: _____	Date Read: _____ Date Read: _____	Induration: _____ mm Induration: _____ mm
<b>OR</b>			
IGRA Tuberculosis Blood Test (Quantiferon®-TB Gold or TSpot®)	Date: _____ Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive > Provide proof of negative chest x-ray (attach report)		
<b>OR</b>			
Chest X-ray <b>(attach report)</b>	Date: _____		
Seasonal Flu Vaccine	If your rotation will be between the dates of November 1 and April 30, please attach a copy of the documentation verifying your receipt of the seasonal flu vaccine.		

Signature of health care provider verifying above  
information: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_