



## Immunizations Documentation and TB Screening Policy for Graduate Students at the UCHC

The Occupational and Environmental Medicine Clinic at the University of Connecticut Health Center is responsible for obtaining adequate documentation and providing a pre-employment evaluation to ascertain immunity to communicable diseases in order to protect the health of all patients, students, staff and employees for the University of Connecticut School of Medicine/Capital Area Health Consortium. This in accordance with Connecticut State Law – Public Act 89-90, federal OSHA mandatory standard and Centers for Disease Control and Prevention (CDC) Guidelines.

**Graduate students in direct contact with patients** are required to have a pre-employment evaluation that includes answering a questionnaire, a brief physical examination, and to complete all portions of the Immunization Documentation and Tuberculosis Screening.

**Graduate students *NOT* in direct contact with patients** are required to have *ONLY* Immunization Documentation and Tuberculosis Screening.

**If you have an Immunization card from your pediatrician, please, send a copy of it to us.**

The Immunization Documentation form must be returned to:

**Occupational and Environmental Medicine  
Medical Records – at The Exchange, Suite 262  
University of Connecticut Health Center  
270 Farmington Avenue  
Farmington, CT 06030-6210**

Contact the Occupational Medicine Clinic for the screening evaluation appointment by calling 860-679-2893 (leave a message and someone will call you back to schedule; if you are out of the country send an e-mail to the program you are joining and ask that to be referred to the Employee Health for an appointment).

Types of documentation required are:

**Measles** (Rubeola) one of the following must be submitted:

- a. Signed physician's record documenting illness **OR**
- b. Signed physician's record documenting two (2) immunizations, one dose after 1969, and one dose after 1980 **AND**
- c. Laboratory report of immune serum antibody titer
- d. Two (2) Measles immunizations must be given one month apart, unless contraindicated

**Rubella:** one of the following must be submitted:

- a. Signed physician's record documenting illness **OR**
- b. Signed physician's record documenting immunization (one dose of MMR) **AND**
- c. Laboratory report on immune serum antibody titer



**Mumps:** one of the following must be submitted:

- a. Signed physician's record documenting immunization (MMR) **AND**
- b. Laboratory report on immune serum antibody titer

**Varicella** immunity by:

- a. Verbal history **OR**
- b. Documentation of 2 doses of Varicella vaccine in the past **AND**
- c. Positive titer

**Hepatitis B (HB)** immunity for those with potential exposure to blood and body fluids by:

- a. Three doses of HB vaccine in the past **AND** a positive titer after at least one month from the third vaccine dose **OR**
- b. Documentation of positive HB antibody titer in the past

**Tuberculosis (TB) Screening** requires submission of:

- a. Two Tuberculin Skin Tests (TST) with negative results, by the Mantoux technique (with purified protein derivative, PPD, 5TU intradermally applied), within the past 12 months **OR**
- b. Results of radiography of the chest for those with a history of a **positive TST or treated TB** in the past (written report is acceptable for an x-ray obtained in the US, otherwise copy of film from a radiography obtained abroad will be necessary)

**Tetanus-diphtheria** toxoid is highly recommended by the CDC to be given every 10 years. Td with **acellular pertussis (Tdap)** is recommended for HCW once in the adult life, 2 years from the last Td.

All graduate students are required to provide complete immunization documentation to be eligible to begin their training program, payroll, or benefits, when employed as well by the University of Connecticut.

Graduate students are expected to provide proof of immunization or obtain the required immunizations before the evaluation at EHS.

Graduate students who cannot get the documentation form signed by their physician but have other immunization records with their physician's signature (i.e., international log, another school or hospital's form) must complete the enclosed form and attach a copy of their previous record. Graduate students cannot sign for themselves.



**\* \* FOR CERTIFICATION PURPOSES ONLY \* \***

University of Connecticut Health Center  
Department of Medicine, Division of Occupational and Environmental Medicine  
Employee Health Service - Incoming Graduate Student Information  
**IMMUNIZATION DOCUMENTATION / SCREENING FORM**

First Name _____	Last Name _____	
Address: _____		
Soc.Security# _____	T00# _____	Date of Birth _____
Status (circle) Medical Resident	Volunteer	High School Minority Program Student
Dental Resident	UCONN Employee	Other - EmployeeUCONN Student
<b>Study Program</b> (if student) (circle) Medicine(MD)	Dental(DMD)	<b>MPH MS PhD Grad School</b>
Law	Social Work	Paramedic
<b>Starting Year / class</b> (if student) <b>2009 yr.</b>		

**MEASLES: (Must have had 2 doses of MMR- one after 1980 AND positive titer for Measles)**

Date of 1st vaccination \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Date of 2nd vaccination \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date of Measles titer \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Result of titer (circle) Immune      Not immune

Date of Mumps titer \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Result of Titer (circle) Immune      Not immune

Immunization against religious beliefs? (circle) Yes No

**RUBELLA: (Must have had one documented dose of MMR AND positive titer for Rubella)**

Date of vaccination \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date of Rubella titer \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Result of titer (circle) Immune      Not immune

Immunization against religious beliefs? (circle) Yes No

**VARICELLA: (Verbal history of positive disease in the past AND positive titer for Varicella- "chickenpox")**

Verbal history of illness. (circle) Yes No

Date of Varicella titer \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Result of titer (circle) Immune      Not immune

**TETANUS DIPHTHERIA or Tdap (Booster recommended every 10 years after initial series)**

Date of last vaccine: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Date of last booster dose \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**TUBERCULOSIS: (MUST HAVE 2 NEGATIVE TUBERCULIN SKIN TESTS WITHIN PAST 12 MONTHS)**

Type PPD \_\_\_\_\_      Date planted \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Result (circle) Positive Negative      Corresponding size \_\_\_\_\_

**NOTE: If positive PPD, Chest x-ray result must be within 12 months.**

**Chest x-ray** date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Result (circle) Positive Negative

**HEPATITIS B: (Mandatory 3 doses AND titer after the 3<sup>rd</sup> dose before starting clinical rotations or lab under BBP OSHA standard)**

Naturally Immune? (circle) Yes No	Previously vaccinated (circle) Yes No
Vaccination Dates: 1st Dose _____ / _____ / _____	4th Dose _____ / _____ / _____
(if known) 2nd Dose _____ / _____ / _____	5th Dose _____ / _____ / _____
3rd Dose _____ / _____ / _____	6th Dose _____ / _____ / _____
Titer 1 Date _____ / _____ / _____	Titer 2 Date _____ / _____ / _____
Titer Result (circle) Positive Negative	Titer Result (circle) Positive Negative

The documentation above was completed by:

\_\_\_\_\_  
Name of Health Care Provider (print)      Telephone Number      Address

\_\_\_\_\_  
Signature of Health Care Provider      Date

**PLEASE RETURN FORM TO:** UCONN Health Center, Division of Occupational and Environmental Medicine, Employee Health Service, 270 Farmington Avenue, Suite 262, Farmington, CT 06030-6210

Entered by: \_\_\_\_\_ Date: \_\_\_\_\_