**IMMUNE STATUS FORM**

Mail, Email or Fax to:
JBT Health & Wellness Center, L587
3181 SW Sam Jackson Park Road
Portland, OR 97239
FAX: 503.494.2958
askJBTRN@ohsu.edu

**REQUARED IMMUNIZATIONS** - Dates must include MM/DD/YYYY if available. Please write clearly or we will be unable to process your form.

Forms still incomplete 2 weeks after matriculation will incur a $95 fee.
Forms still incomplete 4 weeks after matriculation will have a hold placed on the account.

1) **TETANUS/DIPHTHERIA** Required:
   1) Primary series of 3
   2) 1 Tdap booster ->11 years old
   AND
   3) Td booster IF last Td containing vaccine >10 years ago

2) **MEASLES/MUMPS/RUBELLA** Required: One of the following
   1) Two MMR vaccinations
   #1___________
   #2___________
   OR
   2) Immunity confirmed by blood titer (Attach copy of lab report):
      Measles (Rubeola) Date of titer:______________
      Mumps Date of titer:______________
      Rubella Date of titer:______________

3) **HEPATITIS B**
   Required: 3 doses AND positive titer
   (Titer required for all with potential for blood or body fluid exposure. If no patient/animal exposure, vaccine required but titer not needed.)
   Dose #1__________
   Dose #2__________
   Dose #3__________

   AND
   Hep B surface antibody titer to prove immunity if you will have patient or animal exposure Date of titer:______________

   Attach a copy of lab report (Additional vaccinations may be needed if titer is negative) Result ______________

4) **VARICELLA** Required: One of the following:
   1) Documentation of two doses of varicella vaccine: Date #1: ___________ Date #2: ___________
   OR
   2) Laboratory evidence of immunity (Varicella antibody titer)
      Date: ______________ Result: ______________ Attach copy of lab report

5) **TUBERCULIN STATUS** Note: You will also need annual TB test (TST) clearance while at OHSU.
   List dates for two-step TST. Two tests, both negative, at least a week but not more than a year apart, with the second completed less than 12 months before entry to OHSU.
   Required
   1) Skin Test #1: Date: ______________ Result: Neg Pos mm if known ______________
   OR
   2) Skin Test #2: Date: ______________, Result: Neg Pos mm if known

   OR
   Quantiferon TB Gold blood test IF history of positive PPD or BCG vaccine: Date ______________

   If you have a positive TST, submit a chest x-ray report within last year and treatment history. If you had BCG, please obtain a Quantiferon TB Gold test and submit the result.