Wake Forest University School of Medicine
Student & Teammate Health

Office: 336-716-0131
studenthealth@advocatehealth.org

Last Name: _____ First Name: _____Middle Name: _____ DOB: ___/___/___

Measles Mumps Rubella (MMR) Vaccines **OR** **Measles/Rubeola Antibody** **Mumps Antibody**

Date 1: _____/_____/_____ Date: _____/_____/_____ Date: ____/____/____

Date2: _____/_____/_____ Results: ___Positive ___Negative Results: _____Positive____Negative

Rubella Antibody Date: ____/____/____

Results: ___Positive ___Negative

Varicella Vaccines **OR** **Varicella Antibody**

Date 1: _____/_____/_____ Date: _____/_____/_____ Results: ___Positive ___Negative

Date 2: ____/____/_____

Tetanus: All students must submit documentation of 3 doses of tetanus/diphtheria toxoid containing at least one TDAP within the past 10 years prior to matriculation date. (Dtap/TD/Tdap)

Date 1: _____/_____/_____ Date 2: _____/_____/_____ Date 3: _____/_____/_____

Hepatitis B Vaccines **Hepatitis B Surface Antibody Titer**

Date 1: _____/_____/_____ Date: _____/_____/_____

Date 2: _____/_____/_____ **AND** Results: ___Positive ___Negative

Date 3: _____/_____/_____ ** Hepatitis B vaccine is not required if a student was born before July 1, 1994.

Meningococcal Quadrivalent ACYW-135 (Menactra, Menveo)

Dose 1:_____/_____/_____ Dose 2:_____/_____/_____

** Individuals born before January 1, 2003 shall not be required to receive Meningococcal Conjugate Vaccine.

Tuberculosis (TB) Testing: All students must have either **2** Mantoux tuberculin skin tests (TST) or an Interferon Gamma Release Assay (IGRA) no earlier than 1 year prior to matriculation date unless a previous positive test has been documented.

1st Tuberculin Skin Test: Date administered: ___/___/___ Date read: ___/___/___ Result: ____mm

2nd Tuberculin Skin Test: Date administered: ___/___/___ Date read: ___/___/___ Result: ____mm

OR

IGRA/TSpot Lab Test results: Date: _____/_____/_____ Result: ___Positive ___Negative

If Positive documentation of the Mantoux or IGRA lab test: Chest x-ray results required. If Chest x-ray Positive: History of INH treatment and AHWFB TB Questionnaire is required.

Covid Vaccine(s); Recommended, not required.

Mfr: _____ Date: _____/_____/_____ Mfr: _____ Date: _____/_____/_____ Mfr: _____ Date: _____/_____/_____

Seasonal Flu Vaccine Date: _____/_____/_____(Required for current Flu season October1- March 31)

Signature of Health Care Provider or Stamp of Health Care Provider Clinic

_____ **Date: ___/____/_____**