

IMMUNIZATION REQUIREMENT

The University of Arizona College of Pharmacy requires verification of immunity prior to placement at clinical rotation sites. Immunization records must be obtained from your health care provider indicating dates and results of proof of immunity.

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Student ID number		
Mailing Address		

You and/or your health care provider must complete and sign this form. The completed form and **copies of your blood test records** must be mailed to



Director of Experiential Education
The University of Arizona
Pharmacy – Pulido Center
PO Box 210202
Tucson, AZ 85721

Phone: (520) 626-3981

IMMUNIZATION RECORD
(all of the following records are required)

<p>Immunizations and dates:</p> <p><small>(You will not be permitted to register without proof of measles/mumps/rubella (MMR) immunity on file with campus health service)</small></p>	<p>2 MMR vaccinations, at least one of which must have been administered after 12/31/79</p> <p><input type="checkbox"/> MMR #1 Date: month _____ year _____</p> <p><input type="checkbox"/> MMR #2 Date: month _____ year _____</p> <p style="text-align: right;">Health Providers Signature _____</p>
	<p>Hepatitis B completed series</p> <p><input type="checkbox"/> 1st Injection Date: month _____ year _____</p> <p><input type="checkbox"/> 2nd Injection Date: month _____ year _____ (one month after first)</p> <p><input type="checkbox"/> 3rd Injection Date: month _____ year _____ (fives months after second)</p> <p style="text-align: right;">Health Providers Signature _____</p>
	<p>Tetanus</p> <p><input type="checkbox"/> Date: month _____ year _____</p> <p style="text-align: right;">Health Providers Signature _____</p>
<p>Blood testing (proof of immunity) and dates:</p> <p><i>Attach a copy of your blood tests to this form.</i></p>	<p>Proof of "positive" immunity must be documented and <u>attached</u> for the following:</p> <p><input type="checkbox"/> Rubella titer: month _____ year _____ result _____</p> <p><input type="checkbox"/> Rubeola titer: month _____ year _____ result _____</p> <p><input type="checkbox"/> Varicella titer: month _____ year _____ result _____</p> <p><input type="checkbox"/> Hepatitis B titer: month _____ year _____ result _____</p> <p style="text-align: right;">Health Providers Signature _____</p>
<p>Tuberculosis skin test (within last 3 months)</p>	<p>Test Date: Results:</p> <p style="text-align: right;">Health Providers Signature _____</p>