Dear Student,

The health of the individual can affect the health of the campus community. UCSD is committed to protecting the health and well-being of all our students. In order to protect the campus from communicable diseases, immunizations are part of the admission process for **ALL NEW AND RE-ADMITTED STUDENTS** prior to arrival to UCSD.

Read and follow the instructions below:

1. **Print** the Immunization Health Assessment form and visit your health care provider to complete the form and perform all required vaccination(s)/testing. **ENSURE THE FORM IS SIGNED BY YOUR HEALTH CARE PROVIDER or upload an alternative vaccine record.**

2. **ENTER YOUR IMMUNIZATIONS** into your electronic health record: MyStudentChart.ucsd.edu/shs/. Do this AFTER you have had the form filled out, or have your immunization record in front of you.

3. Once you have entered your immunization history, **UPLOAD your signed form/titer results** (details below). The preferred form is a single PDF document (if submitting multiple pages) but image files are also acceptable. If your form is signed by a health provider you do not need to submit individual proof of vaccines.

4. Upload to: MyStudentChart.ucsd.edu/shs/ once your Student Chart portal is available to you.

**Questions:**

1. If you have a **clinical question**, message “Ask a Nurse” in your electronic medical record: MyStudentChart.ucsd.edu/shs/

2. If you are having **technical problems**, email shstb@ucsd.edu and include your student ID number. **Do not include any personal medical information** as this is not a secure method of communication.

3. Refer to the Student Health website for additional information on the health requirements https://wellness.ucsd.edu/studenthealth/health-requirements/Pages/default.aspx

**CONFIRMATION OF RECEIPT OF YOUR DOCUMENT(S) IS NOT POSSIBLE. DO NOT SEND MESSAGES ASKING ABOUT YOUR STATUS.**

Please check your UCSD email regularly for notification of a secure message from Student Health, as there may be a problem with your compliance or form.
<table>
<thead>
<tr>
<th>REQUIRED IMMUNIZATIONS</th>
<th>NOTE: To achieve compliance ensure ALL vaccines are completed.</th>
</tr>
</thead>
</table>
| **Tdap Vaccine**<br>Tetanus/Diphtheria<br>WITH Pertussis (whooping cough) | **ONE DOSE ON OR AFTER THE AGE OF 7 YEARS, OR ONE DOSE IN THE LAST 10 YEARS.**
Dose date (MOST recent date): ________________<br>(Please note: The requirement is Tdap and not Td or Dtap) |

**MMR Vaccine**<br>Measles, Mumps & Rubella<br>**YOU MUST HAVE 2 DOSES WITH THE FIRST DOSE BEING ON OR AFTER YOUR FIRST BIRTHDAY.**
Dose 1 date: ________________ (must be on or after your 1st birthday)<br>(Doses 1 & 2 must be AT LEAST 28 days apart)<br>Dose 2 date: ________________
Dose 3 date: ________________ (booster dose if your 1st dose was before your 1st birthday)

**IF UNABLE TO OBTAIN PROOF OF VACCINATION YOU CAN OBTAIN A BLOOD TEST (TITER).**
- **POSITIVE Measles IgG Antibody Titer**
  Titer date: ________________
- **POSTIVE Mumps IgG Antibody Titer**
  Titer date: ________________
- **POSITIVE Rubella IgG Antibody Titer**
  Titer date: ________________

If you have a negative or indeterminate titer, obtain one dose of MMR and repeat titer 4-6 wks later. If titer is still negative, receive a 2nd dose of MMR and repeat titer 4-6 wks later. Vaccine doses must be at least 28 days apart.

**Varicella (Chicken Pox) Vaccine**
YOU MUST HAVE 2 DOSES WITH THE FIRST DOSE BEING ON OR AFTER YOUR FIRST BIRTHDAY.<br>Dose 1 date: ________________ (must be on or after your 1st birthday)<br>(Doses 1 & 2 must be AT LEAST 28 days apart)<br>Dose 2 date: ________________
Dose 3 date: ________________ (booster dose if your 1st dose was before your 1st birthday)

**IF UNABLE TO OBTAIN PROOF OF VACCINATION OR IF YOU HAD THE DISEASE AS A CHILD, YOU CAN OBTAIN A BLOOD TEST (TITER).**
- **POSITIVE Varicella IgG Antibody Titer**
  Titer date: ________________

If you have a negative or indeterminate titer, obtain one dose of varicella and repeat titer 4-6 wks later. If titer is still negative, receive a 2nd dose of varicella and repeat titer 4-6 wks later. Vaccine must be at least 28 days apart.

**Meningococcal Vaccine**
MCV4/MPSV4 or equivalent for students 22 yrs or younger<br>Recommended for students up to the age of 23<br>THE MOST RECENT DOSE MUST BE ON OR AFTER YOUR 16th BIRTHDAY.
Dose 1 date: ________________
Dose 2 date: ________________<br>(Booster Dose if Dose 2 was PRIOR to the 16th birthday)<br>Dose 3 date: ________________

---

I ATTEST THAT ALL DATES AND IMMUNIZATIONS LISTED ON THIS FORM ARE CORRECT AND ACCURATE

Providers Signature: __________________________ Practice Stamp: __________________________
Provider’s Name: __________________________ Date: ________________
(Physician/PA/NP/RN)
<table>
<thead>
<tr>
<th>STRONGLY RECOMMENDED IMMUNIZATIONS</th>
<th>*NOTE: These vaccinations are recommended BUT NOT required to be compliant with enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Human Papilloma Virus Vaccine (HPV)</strong>&lt;br&gt;3 dose series</td>
<td><strong>RECOMMENDED FOR ALL STUDENTS (ALL GENDERS) UP TO THE AGE OF 26</strong>&lt;br&gt;Dose 1 date: ________________&lt;br&gt;Dose 2 date: ________________&lt;br&gt;Dose 3 date: ________________</td>
</tr>
<tr>
<td><strong>Hepatitis B Vaccine</strong>&lt;br&gt;3 dose series</td>
<td>Positive Hepatitis B IgG antibody Titer date: ________________&lt;br&gt;Dose 2 date: ________________&lt;br&gt;(Heplisav-B is a 2 dose series)&lt;br&gt;Dose 3 date: ________________&lt;br&gt;OR&lt;br&gt;<strong>Heplisav-B</strong>&lt;br&gt;2 dose series</td>
</tr>
<tr>
<td><strong>Meningococcal B Vaccine</strong>&lt;br&gt;Trumebba or Bexoro</td>
<td><strong>RECOMMENDED FOR AGES 16 – 23 YEARS AFTER DISCUSSION WITH A HEALTHCARE PROVIDER</strong>&lt;br&gt;Dose 1 date: ________________&lt;br&gt;Dose 2 date: ________________&lt;br&gt;(Trumebba is either a 2 dose or 3 dose series. Bexero is a 2 dose series)&lt;br&gt;Dose 3 date: ________________</td>
</tr>
<tr>
<td><strong>Hepatitis A Vaccine</strong>&lt;br&gt;2 dose series</td>
<td>Positive Hepatitis A IgG Antibody Titer date: ________________&lt;br&gt;(Dose 2 must be at LEAST 6 months after the first dose)&lt;br&gt;Dose 2 date: ________________&lt;br&gt;If you have a negative or indeterminate titer, obtain one dose of Hep A and repeat titer 4-6 wks later. If titer is still negative, receive a second dose of Hep A and repeat titer 4-6 wks later. Vaccines must be at least 28 days apart.</td>
</tr>
<tr>
<td><strong>Polio Vaccine</strong>&lt;br&gt;4 dose series</td>
<td>Dose 1 date: ________________&lt;br&gt;Dose 2 date: ________________&lt;br&gt;Dose 3 date: ________________&lt;br&gt;Dose 4 date: ________________</td>
</tr>
<tr>
<td><strong>Pneumococcal Vaccine</strong>&lt;br&gt;PSV13 +/-or PPSV23 based on health history</td>
<td>Dose PSV13 date: ________________&lt;br&gt;Dose PPSV23 date: ________________&lt;br&gt;Only recommended for those with a history of asthma, diabetes, smokers and those with immunosuppression due to illness or medication after discussion with your healthcare provider</td>
</tr>
</tbody>
</table>

I ATTEST THAT ALL DATES AND IMMUNIZATIONS LISTED ON THIS FORM ARE CORRECT AND ACCURATE

Providers Signature: ________________________________  Practice Stamp:

Provider’s Name: ________________________________  Date: ________________
(Physician/PA/NP/RN)