UNIVERSITY OF CALIFORNIA, SAN DIEGO
IMMUNIZATION ADMISSION REQUIREMENT

DO NOT UPLOAD THIS INSTRUCTION PAGE INTO YOUR ELECTRONIC HEALTH RECORD
REMEMBER TO BOTH UPLOAD THIS FORM AND SELF-ENTER YOUR DATES ONLINE

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.

Please read and follow the instructions below:

1. **Print** this 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, via Single Sign On (you need your Student PID & your UCSD email account).** Do this AFTER you have had the form filled out, or have your immunization record in front of you. You can partially save your record, but you cannot go back and edit it once dates have been entered **https://shs.ucsd.edu**

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

4. PLEASE select ONE method of submitting your form as multiple submissions may delay your clearance e.g. Upload OR Fax (not both!)

PLEASE CLEARLY NAME YOUR DOCUMENT AS "IMMUNIZATION REQUIREMENTS"

Upload: Student Health Services
Electronic Medical Record
Student portal: **https://shs.ucsd.edu**

OR **Fax:** 1-858-246-2414

Questions:

1. IF you have a **clinical question,** ask it via your Electronic Medical Record "Ask a Nurse – Immunization Requirement" **https://shs.ucsd.edu**
   Please note if your UCSD email is not established we will not be able to respond to your message.
2. If you are having **technical problems** uploading or faxing your form, email **shsmr@ucsd.edu** with your question and be sure to include your student ID number. **Do not include any personal medical information** as this is not a secure method of communication.
3. Please 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.
****PLEASE DO NOT SEND US MESSAGES REGARDING YOUR STATUS, CHECK THE IN THE FOLLOWING PLACES:**

- Undergraduates – check your Immunization status on Applicant Portal or Triton Checklist
- Graduates – check your TB status on the Graduate Division website **http://grad.ucsd.edu/admissions/admitted/index.html**

**If the status has not changed, please check your UCSD email for a secure message from Student Health, as there may be a problem with your compliance or form.

UNIVERSITY OF CALIFORNIA SAN DIEGO IMMUNIZATION REQUIREMENTS

Student ID:	Name: LAST FIRST	Date of Birth:

REQUIRED IMMUNIZATIONS	***NOTE: To achieve compliance ensure ALL vaccines are completed.**
Tdap Vaccine Tetanus/Diphtheria 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): _____ **(Please note: The requirement is Tdap and not Td or Dtap)**
MMR Vaccine Measles, Mumps & Rubella	**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)** **(Dose 1 & 2 must be AT LEAST 28 days apart)** 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.** Dose 1 Date: _____ **(must be on or after your 1st birthday)** **(Dose 1 & 2 must be AT LEAST 28 days apart)** 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)** **POSITIVIE 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 Recommended for students up to the age of 23	**THE MOST RECENT DOSE MUST BE ON OR AFTER YOUR 16th BIRTHDAY.** Dose 1 Date: _____ Dose 2 Date: _____ **(Booster Dose if Dose 2 was PRIOR to the 16th birthday)** 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)

STRONGLY RECOMMENDED IMMUNIZATIONS	*NOTE: These vaccinations are recommended BUT NOT required to be compliant with enrollment
HPV Vaccine Human Papilloma Virus Vaccine 3 dose series	**RECOMMENDED FOR ALL STUDENTS (ALL GENDERS) UP TO THE AGE OF 26** Dose 1 Date: _____ Dose 2 Date: _____ Dose 3 Date: _____
Hepatitis B Vaccine 3 dose series	Dose 1 Date: _____ Dose 2 Date: _____ Dose 3 Date: _____ **POSITIVE** Hepatitis B IgG Antibody Titer Titer Date: _____ • If you have a negative or indeterminate titer, obtain one dose of Hep B 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 must be at least 28 days apart.
Meningococcal B Vaccine Trumemba or Bexero	**RECOMMENDED FOR AGES 16 – 23 YEARS AFTER DISCUSSION WITH A HEALTHCARE PROVIDER** Dose 1 Date: _____ Dose 2 Date: _____ **(Trumemba is either a 2 dose or 3 dose series. Bexero is a 2 dose series)** Dose 3 Date: _____
Hepatitis A Vaccine 2 dose series	Dose 1 Date: _____ **(Dose 2 must be at LEAST 6 months after the first dose)** Dose 2 Date: _____
Polio Vaccine 4 dose series	Dose 1 Date: _____ Dose 2 Date: _____ Dose 3 Date: _____ Dose 4 Date: _____
Pneumococcal Vaccine PSV13 +/or PPSV23 based on health history	Dose PSV13 Date: _____ Dose PPSV23 Date: _____ • 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

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)