

INCOMING IMMUNIZATION REQUIREMENTS FORM

Dear Incoming Student,

In order to protect our campus from communicable disease, **all new and re-admitted graduate and undergraduate students are required to complete required immunizations before arriving at UC San Diego.** This includes undergraduate students transitioning to graduate studies.

Please read and follow the instructions below.



1. **Print** the Immunization Requirements form.



2. **Visit** your health care provider.
 - Have your health care provider complete the form. **The form must be signed by your healthcare provider**, or you can submit an alternative immunization record.
 - Perform all required immunizations or testing. Following the form for directions.



3. **Submit** your immunization requirements form.
 - Go to your electronic health record: MyStudentChart.ucsd.edu. In order to log in to MyStudentChart, you will need your AD username and password.
 - Then go to **Menu > Immunization & Screening > Immunization**
 - Use the completed Immunization form or alternative immunization record to self-enter your immunization dates in the online form. Submit **ALL** vaccine dates.



4. **Upload** your immunization health assessment or alternative immunization record.
 - Once you have self-entered your immunization dates, upload your signed form or alternative vaccine records into MyStudentChart. ((If your form is signed by a health care provider, you do not need to submit individual proof of your immunizations).

Questions:

1. If you have a **medical question (including more information on the medical exemption process)**, use the “Ask-A-Nurse” function in your electronic medical record: MyStudentChart.ucsd.edu.
2. If you are having **technical problems**, email shstb@health.ucsd.edu and include your student ID number. **Do not include any medical information** as this is not a secure method of communication.
3. Please refer to the [Student Health Services website](#) for additional information

You will **not** get a confirmation that your Immunization Requirements Form has been received.

Please check your UCSD email or MyStudentChart regularly for a secure message from Student Health. This is how requests for additional information, updates and reminders are provided by the Nursing team.

INCOMING IMMUNIZATION REQUIREMENTS FORM

Student ID: _____	Name: LAST _____ FIRST _____	Date of Birth: _____
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REQUIRED IMMUNIZATIONS	NOTE: To achieve full 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 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.	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) (Doses 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 Titer POSTIVE Mumps IgG Titer POSITIVE Rubella IgG Titer Titer date: _____ Titer date: _____ Titer date: _____																		
Varicella (Chicken Pox) Vaccine 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.	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) (Doses 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) POSITIVE Varicella IgG Titer Titer date: _____																		
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: _____																		
COVID-19 Vaccine FDA or WHO-Approved doses received OR <input type="checkbox"/> I affirmatively decline the COVID vaccine at this time Initials: _____ Date: _____	<table border="0"> <tr> <td>Please circle:</td> <td>Primary Series (1 or 2) dose vaccine</td> <td>Booster/Additional Dose(s)</td> </tr> <tr> <td>Pfizer, Moderna, Janssen,</td> <td>Dose 1 date: _____</td> <td>Dose 1 date: _____</td> </tr> <tr> <td>Covisheild, Sinopharm,</td> <td>Dose 2 date: _____</td> <td>Dose 2 date: _____</td> </tr> <tr> <td>Sinovac-CoronaVac,</td> <td></td> <td>Dose 3 date: _____</td> </tr> <tr> <td>Covaxin, AstraZeneca,</td> <td>Please upload proof of vaccine</td> <td>Dose 4 date: _____</td> </tr> <tr> <td>Novavax, CanSino</td> <td></td> <td></td> </tr> </table> Please go to Menu > COVID-19 to self-enter dates and upload proof of Covid vaccines only	Please circle:	Primary Series (1 or 2) dose vaccine	Booster/Additional Dose(s)	Pfizer, Moderna, Janssen,	Dose 1 date: _____	Dose 1 date: _____	Covisheild, Sinopharm,	Dose 2 date: _____	Dose 2 date: _____	Sinovac-CoronaVac,		Dose 3 date: _____	Covaxin, AstraZeneca,	Please upload proof of vaccine	Dose 4 date: _____	Novavax, CanSino		
Please circle:	Primary Series (1 or 2) dose vaccine	Booster/Additional Dose(s)																	
Pfizer, Moderna, Janssen,	Dose 1 date: _____	Dose 1 date: _____																	
Covisheild, Sinopharm,	Dose 2 date: _____	Dose 2 date: _____																	
Sinovac-CoronaVac,		Dose 3 date: _____																	
Covaxin, AstraZeneca,	Please upload proof of vaccine	Dose 4 date: _____																	
Novavax, CanSino																			

Providers Signature: _____	Practice Stamp: _____
Provider's Name: _____	Date: _____

HIGHLY RECOMMENDED IMMUNIZATIONS	*NOTE: These vaccinations are recommended BUT NOT required to be compliant with enrollment
Human Papilloma Virus Vaccine (HPV) 2 dose series if started before the age of 15. 3 dose series if started after the age of 15.	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 OR Heplisav-B 2 dose series	Dose 1 date: _____ Positive Hepatitis B IgG antibody Titer date: _____ Dose 2 date: _____ Dose 3 date: _____ (Heplisav-B is a 2 dose series) 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 Hep B and repeat titer 4-6 wks later. Vaccines 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: _____ Positive Hepatitis A IgG Antibody Titer date: _____ (Dose 2 must be at LEAST 6 months after the first dose) Dose 2 date: _____ 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.
Polio Vaccine 4 dose series	Dose 1 date: _____ Dose 2 date: _____ Dose 3 date: _____ Dose 4 date: _____
Pneumococcal Vaccine(s) PCV13, PCV15, PCV20 +/-or PCV23 based on health history	Dose PSV13 date: _____ Dose PSV15 date: _____ Dose PPSV23 date: _____ Dose PPSV20 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