University of Nebraska Medical Center
BREAKTHROUGHS FOR LIFE.

Required Visitor Immunization Form (2-sided)

Enter all data, including dates. Incomplete forms will be returned.

Please check your campus:
❑ Omaha ❑ Lincoln
❑ Norfolk ❑ Kearney
❑ Gering ❑ Scottsbluff

Family Name _____ **First Name** _____ **Middle Initial** _____ **Date of Birth** _____

Permanent Address: _____

E-mail address: _____

MMR **Rubeola, Mumps, Rubella** (Measles, Mumps, German Measles)	Evidence **of 2 doses** of MMR **OR** Evidence of immunity documented by antibody titer. (If titer is not positive, a booster is required.)	Date 1st MMR ____/____/____ MM DD YY	Date 2nd MMR ____/____/____ MM DD YY	Titer Date ____/____/____ MM DD YY ❑ Immune ❑ Not Immune	Booster Date ____/____/____ MM DD YY
Chicken Pox **(**Varicella**)**	Evidence of 2 doses of varicella **OR** Evidence of immunity documented by antibody titer. (If titer is not positive, a booster is required.)	Date 1st Varicella Vaccination ____/____/____ MM DD YY	Date 2nd Varicella Vaccination ____/____/____ MM DD YY	Titer Date ____/____/____ MM DD YY ❑ Immune ❑ Not Immune	Booster Date ____/____/____ MM DD YY
Tetanus/Diptheria/ Pertussis	Evidence of 1 Tdap after 18th birthday. AND Evidence of a Td booster if more than 10 years from last Tdap or Td	Tdap (required) ____/____/____ MM DD YY	Td Booster Date If Tdap or Td more than 10 years ago ____/____/____ MM DD YY		
Tuberculosis Screening (Must be within 6 months prior to start date) ❑ Coming from outside the US ❑ Screen form completed	***Category 1*:** Evidence of 2 consecutive years of negative TB skin tests. One test must be within 6 months prior to start date. ***OR***	Date Negative: ____/____/____ MM DD YY _____ mm induration	Date Negative:____/____/____ MM DD YY _____ mm induration		
	Category 2: Visitors who have NOT had 2 PPD skin tests in the past 2 years must have a 2-step PPD within 6 months prior to start date. *(A 2 step PPD is defined as 2 negative skin tests done at least 7 days apart.)* ***OR***	Date Negative:____/____/____ MM DD YY _____ mm induration	Date Negative:____/____/____ M DD YY _____ mm induration		
	Category 3: i. Visitors having a POSITIVE skin test in the past must have documentation of a TB *Interferon-Gamma Release Assay** (IGRA) prior to start date. ii. Visitors who have not tested POSITIVE to the PPD skin test have the choice of either providing Negative results to the two-step PPD skin test or IGRA testing which is within 6 months prior to start date. *One example is **QuanteFERON Gold**	**BCG Vaccine Date:** ____/____/____ MM DD YY Gamma interferon Release Assay Test Date: ____/____/____ MM DD YY Result: ❑ Normal ❑ Abnormal (explain): _____			

For any **POSITIVE TB** test, provider must document steps taken:
Chest X-ray date: ____/____/____ MM DD YY Result: ❑ Normal ❑ Abnormal (explain): _____

INH Treatment Dates: _____ to _____

Hepatitis B	Evidence of Hepatitis B immunity documented by antibody titer. If titer remains negative after the first series, visitor must repeat a second series with a repeated titer. If titer remains negative, testing for active Hepatitis B is indicated and if evidence of Hepatitis B infection is lacking, the individual is considered to be a "non-responder."	#1 Date ____/____/____ MM DD YY #1 Date ____/____/____ MM DD YY	#2 Date ____/____/____ MM DD YY #2 Date ____/____/____ MM DD YY	#3 Date ____/____/____ MM DD YY #3 Date ____/____/____ MM DD YY	Titer Date ____/____/____ MM DD YY Titer Date ____/____/____ MM DD YY	❑ Immune ❑ Not Immune ❑ Immune ❑ Not Immune
Polio Vaccine		Vaccine Date ____/____/____ MM DD YY				
Flu Vaccine	**College of Nursing Only**	Vaccine Date ____/____/____ MM DD YY				

I verify that the immunization records are complete and accurate to the best of my knowledge.

Signature of Visitor: _____ **Date**: _____

Signature of Health Care Provider (physician): _____ **Date**: _____

Name of Health Care Provider (physician): _____ **Provider Phone #:** _____

Health Care Provider's Full Address: _____

PLEASE RETURN THE FORM TO:
NASREEN W. MAIWANDI
International Health and Medical Education
985700 Nebraska Medical Center
Omaha, NE 68198-5700

Phone: (402) 559-6414 **Fax**: (402) 559-3175 **E-mail**: maiwandi@unmc.edu

PLEASE NOTE:

YOU WILL NOT BE ALLOWED TO BE ON CAMPUS UNTIL YOU COMPLETE ALL YOUR IMMUNIZATIONS/VACCINATIONS AND PROVIDE YOUR LABORATORY REPORTS (TO BACK UP THE IMMUNIZATIONS**).**