UNIVERSITY AT BUFFALO

117 CARY HALL, UNIVERSITY AT BUFFALO
BUFFALO NY 14214 (716) 961-9412

IMMUNIZATION DOCUMENTATION

TO BE COMPLETED AND SIGNED BY ATTENDING PHYSICIAN'S OFFICE OR HEALTH DEPARTMENT OR ATTACH COPIES OF IMMUNIZATION RECORDS. IMMUNITY BY TITER WILL BE ACCEPTED ONLY IF A COPY FO THE ACTUAL LAB TEST RESULTS ARE INCLUDED. YOU MUST BRING COMPLETED DOCUMENT TO YOUR PRE-EMPLOYMENT PHYSICAL.

Name:___________________________ D.O.B. ________

	MO/DAY/YEAR	MO/DAY/YEAR	MO/DAY/YEAR	MO/DAY/YEAR
DTP, DT, or TD: Childhood or Tetanus-Diphtheria tD or Adult Basic series of three doses.				
Tdap (One dose required)				
MUMPS: one dose live vaccine is required or proof of immunity by positive blood test (titer). Specify if MMR.		Disease Date:	ATTACH TITER*	
RUBEOLA (Measles): Two doses required if born 1957 or later. Physician certified history of disease or live vaccines given ON or AFTER first birthday and after 1/1/69 or proof of immunity by positive blood test (titer). Note: MR or MMR must be after 4/22/71 and 1st birthday. Specify if MR or MMR.			Disease Date:	ATTACH TITER*
RUBELLA (German Measles): One dose live vaccine required. Vaccines (after 6/9/69) or proof of immunity by positive blood test (titer). Note: MR or MMR must be after 4/22/71 and 1st birthday. Specify if MR or MMR.			History of Disease NOT ACCEPTED	ATTACH TITER*
HEPATITIS B: Series of 3 doses or proof of immunity by positive blood test (titer). (HBcAB or HBsAB positive).				ATTACH TITER*
VARICELLA (Chicken Pox): Series of two doses or immunity by positive blood titer or physician documented history of disease.			Disease Date:	ATTACH TITER*
TB SKIN TEST AND RESULT: Required within the past 12 months unless physician documented positive PPD (date and mm of induration) or physician documented treatment for TB. Chest x-ray after date of documented positive PPD (copy of x-ray report must be included).	TB Skin test date: RESULT: __mm Induration __ mm Erythema		Chest X-Ray Date: RESULT: (attach copy)	

*PLEASE ATTACH ACTUAL LABORATORY BLOOD TITER IF AVAILABLE AS PROOF OF IMMUNITY

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Physician Signature or Health Dept. Stamp verifying immunizations Office Address Date