

This form is required for all international students pursuing Study Abroad in UCLA and UCLA Extension Credit and Certificate programs. Please complete and return this form at least 30 days before the program start date.

Name: LAST FIRST	Date of Birth (MM/DD/YYYY):
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REQUIRED IMMUNIZATIONS	
<p>Tdap Vaccine</p> <ul style="list-style-type: none"> • Tetanus/Diphtheria WITH Pertussis (whooping cough) 	<p>ONE DOSE ON OR AFTER AGE 7 YRS FOR Non-Health Care Professional Students</p> <p>ONE DOSE IN THE LAST 10 YRS required for Health Care Professional Students</p> <p>Dose Date: _____</p> <p>(Please note: The requirement is Tdap and not Td or Dtap)</p>
<p>MMR Vaccine</p> <ul style="list-style-type: none"> • Measles, Mumps & Rubella 	<p>YOU MUST HAVE 2 DOSES WITH THE FIRST DOSE BEING ON OR AFTER YOUR FIRST BIRTHDAY.</p> <p>Dose 1 Date: _____ (must be on or after your 1st birthday)</p> <p>(Dose 1 & 2 must be AT LEAST 28 days apart)</p> <p>Dose 2 Date: _____</p> <p>IF UNABLE TO OBTAIN PROOF OF VACCINATION, YOU MUST OBTAIN A BLOOD TITER TEST.</p> <p>* ATTACH A COPY OF YOUR LAB REPORT</p> <p>POSITIVE Measles IgG Antibody Titer Titer Date: _____</p> <p>POSITIVE Mumps IgG Antibody Titer Titer Date: _____</p> <p>POSITIVE Rubella IgG Antibody Titer Titer Date: _____</p> <ul style="list-style-type: none"> • If you have a negative or indeterminate titer, obtain one dose of MMR vaccine and repeat titer 4 wks later. If titer is still negative, receive a 2nd dose of MMR.
<p>Varicella (Chicken Pox) Vaccine</p>	<p>YOU MUST HAVE 2 DOSES WITH THE FIRST DOSE BEING ON OR AFTER YOUR FIRST BIRTHDAY.</p> <p>Dose 1 Date: _____ (must be on or after your 1st birthday)</p> <p>(Dose 1 & 2 must be AT LEAST 28 days apart)</p> <p>Dose 2 Date: _____</p> <p>IF YOU HAD THE DISEASE AS A CHILD OR IF YOU ARE UNABLE TO OBTAIN PROOF OF VACCINATION, YOU MUST OBTAIN A BLOOD TITER TEST.</p> <p>POSITIVE Varicella IgG Antibody Titer Titer Date: _____</p> <ul style="list-style-type: none"> • If you have a negative or indeterminate titer, obtain one dose of varicella vaccine and repeat titer 4 wks later. If titer is still negative, receive a 2nd dose of varicella vaccine.
<p>Meningococcal Vaccine</p> <ul style="list-style-type: none"> • MCV4 (Menactra or Menveo brand preferred) REQUIRED for ALL students 21 yrs or younger 	<p>THE MOST RECENT DOSE MUST BE ON OR AFTER THE 16TH BIRTHDAY.</p> <p>Dose 1 Date: _____</p> <p>Dose 2 Date: _____</p>

Tuberculosis (TB) Questionnaire

Name: LAST	FIRST	Date of Birth (MM/DD/YYYY):
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Please answer the following questions:

- Have you ever had a positive TB skin or blood test? Yes No
- Have you ever had close contact with anyone who was sick with TB? Yes No
- Are you from or have you ever lived or traveled in one of the following areas: Mexico, South or Central America, Eastern Europe, Asia, the Middle East, or Africa? Yes No

If all questions are answered **NO**, you have completed your TB Assessment.

If any questions are answered **YES**, then **you must also have your health care provider complete the TB Assessment below**, documenting either treatment for TB or negative TB test results. This must be completed and submitted to UCLA Extension thirty (30) days before the start of your program. **If TB results are required, the TB test must be taken no more than 1 year from the program start date.**

Tuberculosis (TB) Assessment This part of the form must be completed only by a licensed health care provider.

RISK FACTORS: (please ask student and check any that apply)

- 1. Immunosuppressed (HIV/AIDS), organ transplant, or on immunosuppressant medication Yes No
- 2. History of abnormal chest x-ray suggestive of TB disease Yes No
- 3. Does the student have signs or symptoms of active tuberculosis disease? Yes No
(Cough more than 3 weeks, chest pain, unexplained weight loss, fevers, night sweats)

If no, proceed to 4 or 5. If yes, proceed with additional evaluation to exclude active TB, including TB skin or blood testing, chest x-ray, and sputum evaluation as indicated, and show results below.

4. Tuberculin Skin Test (TST) If there is no history of BCG Vaccine, TST results should be recorded as millimeters (mm) of induration. If no induration, write "0." Five mm is considered positive if there is a history of abnormal chest x-ray, recent exposure to active TB disease, or is immunosuppressed. 10 mm induration is considered positive if coming from a high-risk area or has other high-risk conditions (IV drug use, chronic renal disease, cancer, diabetes, malabsorption or GI bypass).

- Date TST test was given: _____ month/day/year
- Date TST test was read: _____ month/day/year
- Result: _____ mm induration
- Interpretation: negative positive

5. TB Blood Test (Interferon Gamma Release Assay-IGRA) The TB blood test may be done instead of TST. Strongly recommended if there is a history of positive TST or BCG vaccination.

- Date obtained: _____ month/day/year
- Result: negative positive intermediate

6. Chest X-Ray (required if TST or IGRA is positive)

- Date of chest x-ray: _____ month/ day/ year
- Result: normal abnormal (including scars, and old granulomatous changes)

If chest x-ray is abnormal, please submit the following results.

Sputum Results (AFB and culture x 3 required if chest x-ray abnormal):

- #1 Date _____ AFB _____ Culture _____
- #2 Date _____ AFB _____ Culture _____
- #3 Date _____ AFB _____ Culture _____

7. Treatment for Latent TB (if applicable):

- Medication(s) _____
- Start date: _____ month/day/year
- Completion date: _____ month/day/year

	*NOTE: These vaccinations are recommended BUT NOT required to be compliant with enrollment.	
HPV Vaccine <ul style="list-style-type: none"> Human Papilloma Virus Vaccine 3 dose series 	RECOMMENDED FOR ALL STUDENTS (ALL GENDERS) UP TO THE AGE OF 26 HPV 4 Dose 1 Date: _____ Dose 2 Date: _____ Dose 3 Date: _____	RECOMMENDED FOR ALL STUDENTS (ALL GENDERS) UP TO THE AGE OF 26 HPV 9 Dose 1 Date: _____ Dose 2 Date: _____ Dose 3 Date: _____
Meningococcal B Vaccine <ul style="list-style-type: none"> Trumemba or Bexsero 	RECOMMENDED FOR AGES 16-23 AFTER DISCUSSION WITH A HEALTH CARE PROVIDER Dose 1 Date: _____ Dose 2 Date: _____ (Trumemba is either a 2 dose or 3 dose series. Bexsero is a 2 dose series) Dose 3 Date: _____	
Hepatitis A Vaccine <ul style="list-style-type: none"> 2 dose series 	Dose 1 Date: _____ (Dose 2 should be 6-12 months following first) Dose 2 Date: _____	
Polio Vaccine <ul style="list-style-type: none"> 4 dose series 	Dose 1 Date: _____ Dose 2 Date: _____ Dose 3 Date: _____ Dose 4 Date: _____	
Pneumococcal Vaccine <ul style="list-style-type: none"> PCV13 +/-or PPSV23 based on health history 	Dose PCV13 Date: _____ Dose PPSV23 Date: _____ <ul style="list-style-type: none"> Only recommended for those with a history of asthma, diabetes, smokers and those with immunosuppression due to illness or medication after discussion with your health care provider 	

UCLA Extension has no responsibility for verifying the accuracy of the information provided on this form.*

I ATTEST THAT ALL DATES AND IMMUNIZATIONS LISTED ON THIS FORM ARE CORRECT AND ACCURATE	
Student's Signature: _____	Date: _____
Provider's Signature: _____	Practice Stamp: _____
Provider's Name: _____	Date: _____
(Physician/PA/NP/RN)	

**As an educational institution, UCLA Extension treats the immunization information provided herein as personal confidential information in a student's record protected under the Family Educational Rights and Privacy Act of 1974 (FERPA). Thereby, this immunization information will be stored securely and not released to any outside entity.*