CHSU CALIFORNIA HEALTH SCIENCES UNIVERSITY

MASTER OF SCIENCE IN BIOMEDICAL SCIENCES

# Student Immunizations

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# Student Health Immunization Requirements

CHSU requires that students meet all immunization requirements prior to matriculation and must maintain compliance with these requirements through graduation. Descriptions of CHSU immunization requirements specifically addressing Varicella, Measles, Mumps, Rubella, Hepatitis B, Tuberculosis, Influenza, Tetanus/Diphtheria/Pertussis (TDAP), and COVID-19 are presented below.

Required laboratory evaluations and immunizations are subject to review and modification based on recommendations from the Centers for Disease Control (CDC), the Advisory Committee on Immunization Practices (ACIP), the United States Prevention Task Force (USPTF,) and other public health agencies. Students will be notified of any changes and will be required to comply with any mandated changes upon receipt of notice from CHSU, within a period of 30 days.

## Important Notes Regarding Vaccination Requirements:

1. Exemptions may be obtained for medical or religious reasons.

2. Students will **not** be allowed to participate in classes and any health outreach events until **all** immunization requirements have been met.

CHSU immunization requirements are described in detail below. All incoming and current students must log all immunization requirements on the CHSU immunization form. **This form must be completed in its entirety; students are required to upload it to SONIS.**

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Student Name: Last, First _____ DOB: _____
Cell Phone: _____ Email: _____

## COVID-19 & Seasonal Flu

COVID Vaccination: Provide current vaccination, including primary series and booster(s) as per CDC current guidelines.

Seasonal Flu Vaccination: Provide documentation of current annual vaccination.

- Flu vaccination is to be completed by **October 1, each year of enrollment.**

| | | Date | Series # or QR Code | MRT Upload/Verified |
|---|---|---|---|---|
| **Pfizer-BioNTech** 2-Doses of Vaccine and Booster | Pfizer-BioNTech dose 1 | | Lot # _____ or QR Code | |
| | Pfizer-BioNTech dose 2 | | Lot # _____ or QR Code | |
| **Moderna** 2-Doses of Vaccine | Moderna dose 1 | | Lot # _____ or QR Code | |
| | Moderna dose 2 | | Lot # _____ or QR Code | |
| **Johnson & Johnson** (Janzen) 1-Doses of Vaccine | J & J dose 1 | | Lot # _____ or QR Code | |
| | | | Lot # _____ or QR Code | |
| **Booster** At least 5 months after completing Pfizer or Moderna primary COVID-19 vaccination series | Pfizer-BioNTech Booster | | Lot # _____ or QR Code | |
| At least 2 months after receiving J&J/Janssen COVID-19 vaccination | Moderna Booster | | Lot # _____ or QR Code | |
| **Influenza** 1 dose annually each fall | Seasonal Flu Vaccine | | Name: | |

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## Hepatitis B

Provide documentation of 2 /3 Hepatitis B vaccines OR a quantitative titer is required.
If negative titer (<10 IU/ml) is provided students must:

- Repeat the vaccination series: 2-shot Heplisav-B series OR the 3-shot series (Engerix-B, Recombivax, Twinrix).
- Repeat quantitative titer.
- Submit documentation of:
  - 2-dose vaccine (Heplisav-B)
  - **OR** 3-dose vaccine (Engerix-B, Recombivax, Twinrix)
- Submit repeat Quantitative titer results.

For more information, visit: http://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf

| | | | | |
|---|---|---|---|---|
| **QUANTATIVE** Hep B Surface Antibody (Anti HBs) | | **Date** | | **MRT Upload/Verified** |
| | | | _____IU/ml | |
| **If negative titer (<10 IU/ml) provided**<br>**students must repeat** the 2-shot Heplisav-B series **OR** the 3-shot series ((Engerix-B, Recombivax, Twinrix)<br>**Followed by a repeat Quantitative Titer** | **Vaccination Series** | **3 Dose Vaccine Administered** (Engerix-B, Recombivax, Twinrix) | **2 Dose Vaccine Administered** (Heplisav-B) | **MRT Upload/Verified** |
| | Hepatitis B Vaccine #1 | | | |
| | Hepatitis B Vaccine #2 | | | |
| | Hepatitis B Vaccine #3 | | | |
| | **QUANTATIVE** Hep B Surface Antibody (Anti HBs) | | _____IU/ml | |
| **Hepatitis B Vaccine Non-responder** (If Hepatitis B Surface Antibody Negative after Primary and Secondary Series) | Hepatitis B Surface Antigen | | ◯ Positive ◯ Negative | |
| | Hepatitis B Core Antibody | | ◯ Positive ◯ Negative | |
| **Chronic Active Hepatitis B** | Hepatitis B Surface Antigen | | ◯ Positive ◯ Negative | |
| | Hepatitis B Viral Load | | _____ copies/ml | |

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## Measles, Mumps and Rubella (MMR)

Provide documentation of 2 MMR vaccines OR a positive antibody Titer showing immunity.
If negative Titer is provided, students must:

- Obtain booster vaccination.
- Repeat Quantitative Titer.
- Submit documentation of booster vaccination.
- Submit repeat Quantitative Titer results.

*Note: A 3rd-dose of MMR vaccine may be advised during regional outbreaks of measles or mumps if original MMR vaccination was received in childhood.

| Option 1 | Vaccine | Date | | MRT Upload/Verified |
|---|---|---|---|---|
| **MMR** 2-Doses of MMR Vaccine | MMR Dose 1 | | | |
| | MMR Dose 2 | | | |
| | MMR Dose 3 | | | |
| **Option 2** | **Vaccine or Titer Test** | **Date** | | |
| **Measles** 2 doses of vaccine or positive serology | Measles Vaccine Dose 1 | | **Serology Results** | |
| | Measles Vaccine Dose 2 | | Qualitative Titer Results ◯ Positive ◯ Negative | |
| | Serologic Immunity (IgG antibody titer) | | Quantitative Titer Results _____ UI/ml | |
| **Mumps** 2 doses of vaccine or positive serology | Mumps Vaccine Dose 1 | | **Serology Results** | |
| | Mumps Vaccine Dose 2 | | Qualitative Titer Results ◯ Positive ◯ Negative | |
| | Serologic Immunity (IgG antibody titer) | | Quantitative Titer Results _____ UI/ml | |
| **Rubella** 1 dose of vaccine or positive serology | | | **Serology Results** | |
| | Rubella Vaccine Dose 1 | | Qualitative Titer Results ◯ Positive ◯ Negative | |
| | Serologic Immunity (IgG antibody titer) | | Quantitative Titer Results _____ UI/ml | |

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## TDAP Vaccination Series

Provide documentation of a current TDAP (tetanus/diphtheria/pertussis) vaccine.
TDAP is considered current if administered within 10 years.

- Required to repeat when expires.
- TD or DTAP will not be accepted.

| | Date | | MRT Upload/Verified |
|---|---|---|---|
| Tdap Vaccine (Adacel, Boostrix, etc) | | | |
| Tdap Vaccine Booster (If more than 10 years since last Tdap) | | | |

## Tuberculosis Screening

Provide documentation of QuantiFERON TB GOLD test within the last 12 months.

- Note: Annually required each year of enrollment.

If the results are positive, please provide a clear chest X-ray.
Note: TB Skin Tests & T-spot tests are not accepted.

| | | Date | Result | Interpretation | MRT Upload/Verified |
|---|---|---|---|---|---|
| **TB IGRA (QuantiFERON Gold)** (Interferon Gamma Release Assay) | | | | ◯ Positive ◯ Negative | |
| TB Status-Chest X-ray | | | Results: | | |
| **TB INH treatment** | | | ◯ Yes | ◯ No | |
| If treated for latent TB, list medications taken: | | | | | |
| Total duration of treatment latent TB? | | | _____ Months | | |
| **History of Active Tuberculosis** | Date of Diagnosis | | | | |
| | Date of Treatment Completed | | | | |
| | Date of Last Chest X-ray | | | | |

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## Varicella (Chicken Pox)

Provide documentation of 2 Varicella vaccines OR a positive antibody Titer showing immunity.
If titer is negative, students must:

- Obtain booster.
- Repeat quantitative titer.
- Submit documentation of booster vaccination.
- Submit repeat Quantitative titer results.

| | Date | | | MRT Upload/Verified |
|---|---|---|---|---|
| Varicella Dose 1 | | **Serology Results** | | |
| Varicella Dose 2 | | Qualitative Titer Results | ◯ Positive ◯ Negative | |
| Serologic Immunity (IgG antibody titer) | | Quantitative Titer Results | _____UI/ml | |

**MUST BE COMPLETED BY YOUR HEALTH CARE PROVIDER OR INSTITUTIONAL DESIGNEE**

| | | | |
|---|---|---|---|
| Authorized Signature | | Date | |
| Printed Name | | Office Use Only | |
| Title | | | |
| Address Line 1 | | | |
| Address Line 2 | | | |
| City | | | |
| State | | | |
| Zip | | | |
| Phone | | | |
| Fax | | | |
| Email Contact | | | |