UCLA Extension

2021-2022 UCLA EXTENSION STUDY ABROAD IMMUNIZATION REQUIREMENTS

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):

REQUIRED IMMUNIZATIONS	
Tdap Vaccine • Tetanus/Diphtheria WITH Pertussis (whooping cough)	**ONE DOSE ON OR AFTER SEVEN YEARS OF AGE FOR NON-HEALTH CARE PROFESSIONAL STUDENTS** **ONE DOSE IN THE LAST 10 YEARS required for health care professional students** Dose Date: _______________ **(Please note: The requirement is Tdap and not Td or Dtap.)**
MMR Vaccine • Measles, Mumps & Rubella	**YOU MUST HAVE TWO DOSES WITH THE FIRST DOSE BEING ON OR AFTER YOUR FIRST BIRTHDAY.** Dose 1 Date: _______________ **(must be on or after your first birthday)** **(Dose 1 & 2 must be AT LEAST 28 days apart)** Dose 2 Date: _______________ **If unable to obtain proof of vaccination, you must obtain a blood titer test.** *** ATTACH A COPY OF YOUR LAB REPORT** **POSITIVE Measles IgG Antibody Titer** Titer Date: _______________ **POSITIVE Mumps IgG Antibody Titer** Titer Date: _______________ **POSITIVE Rubella IgG Antibody Titer** Titer Date: _______________ • If you have a negative or indeterminate titer, obtain one dose of MMR vaccine and repeat titer four weeks later. If titer is still negative, receive a second dose of MMR.
Varicella (Chicken Pox) Vaccine	**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 first birthday)** **(Dose 1 & 2 must be AT LEAST 28 days apart)** Dose 2 Date: _______________ **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.** **POSITIVE Varicella IgG Antibody Titer** Titer Date: _______________ • If you have a negative or indeterminate titer, obtain one dose of varicella vaccine and repeat titer four weeks later. If titer is still negative, receive a second dose of varicella vaccine.
Meningococcal Vaccine • MCV4 (Menactra or Menveo brand preferred) REQUIRED for ALL students 21 yrs or younger	**THE MOST RECENT DOSE MUST BE ON OR AFTER THE 16TH BIRTHDAY.** Dose 1 Date: _______________ Dose 2 Date: _______________

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Tuberculosis (TB) Questionnaire

Name: LAST FIRST	Date of Birth (MM/DD/YYYY):

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 • 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: ______________ **OR** **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 • 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 two-dose or three-dose series. Bexsero is a two-dose series)** Dose 3 Date: ______________
Hepatitis A Vaccine • 2 dose series	Dose 1 Date: ______________ **(Dose 2 should be administered 6-12 months following first dose.)** Dose 2 Date: ______________
Polio Vaccine • 4 dose series	Dose 1 Date: ______________ Dose 2 Date: ______________ Dose 3 Date: ______________ Dose 4 Date: ______________
Pneumococcal Vaccine • PCV13 +/or PPSV23 based on health history	Dose PCV13 Date: ______________ Dose PPSV23 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 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.*