# UW-La Crosse- Gundersen- Mayo- Marshfield
# Physician Assistant Program Required Immunizations

Name:_____ Date of Birth: _____ PA Class of:_____

Please complete the form and **attach a copy of your immunization record, Hepatitis B titer results (required for all), Varicella titer results (if required), & TB skin test results. Providing self-reported dates and results is not sufficient.** Official documentation from a healthcare professional or organization of your immunization record, titer results, & TB skin test results is required. Keep a copy of this form and the required records for yourself and turn in the original form and copy of required records to the Health Professions Department. (4035 Health Science Center or emielke@uwlax.edu)

| DISEASE | REQUIREMENTS | DATE COMPLETED |
|---|---|---|
| **Hepatitis B** | **Immunization** (3 doses)<br>**AND**<br>**Immune titer**<br>(drawn within past 5 years)<br><br>*If not previously immunized, you must plan to receive the immunization series during the first 6 months of enrollment in the PA Program & show proof of an immune titer | Hep. B dose #1:_____<br>Hep. B dose #2:_____<br>Hep. B dose #3:_____<br><br>Hep. B Titer:_____<br>☐ Pos/immune<br>☐ Neg/not immune |
| **MMR**<br>**(Measles (Rubeola),**<br>**Mumps, Rubella**<br>**(German Measles)** | **Immunization** (2 doses) | MMR vaccine dates:<br>MMR Dose #1:_____<br>MMR Dose #2:_____ |
| **Polio** | **At least 3 doses of polio vaccine required** | Type of vaccine:<br>_____<br><br>Polio vaccine dates:<br>_____ |
| **Tetanus/Diphtheria/Pertussis** | **Immunization**<br>(at least 2 doses; at least 1 Tdap)<br>**AND**<br>**evidence of Td booster**<br>**within last 10 years** | Tdap Vaccine dates:<br>_____<br><br>Td Booster within last 10 years:<br>_____ |
| **Varicella (Chicken Pox)** | **Immunization** (2 doses)<br>**OR**<br>**Immune titer** | Varicella dose #1: _____<br>Varicella dose #2: _____<br>OR<br>Varicella Titer:_____<br>☐ Immune ☐ Not immune |

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|---|---|---|
| **Tuberculosis (TB)** | **A 2-Step TB skin test is required initially. Then just one annual TB skin test is required annually for the program.**<br>Know that a repeat 2-step TB skin test may be required by clinical site(s).<br><br>*A TB blood test is also acceptable<br><br>*A chest x-ray is required within last 6 months if a TB test result is positive | **TB (PPD) skin test**<br>#1 result date:_____<br>☐ Positive ☐ Negative<br><br>#2 result date:_____<br>☐ Positive ☐ Negative<br><br>**TB Blood Test**<br>Type:_____<br>Date:_____<br>☐ Positive ☐ Negative<br><br>Positive result: Chest x-ray within last 6 months: _____ |
| **COVID-19 Vaccination** | * Covid vaccination is required for clinical rotation participation.<br><br>It is imperative that you are aware of and adhere to the current policies of the clinical site where you are training, as they may supersede the program's policies. Failure to provide proof of vaccination, or supplemental information as dictated by the clinical site will prohibit you from clinical training at the site. The program is not able to re-assign you to another clinical site. | **Medical Documentation of Full Covid-19 Vaccination Series including any boosters**<br><br>Type(s):_____<br>Date(s):_____<br>_____<br><br>**Exemptions:**<br>Medical and religious exemptions may or may not be granted at the discretion of the clinical base site. |

It is the responsibility of the student to retain records and to provide documentation as requested by the clinical facility and to provide the UW-La Crosse Department of Health Professions with a copy of this form, his/her immunization records, titer lab results, and TB skin test results. The student is responsible for knowing and complying with the requirements of the clinical facility to which they are assigned.

I hereby authorize the Health Professions Department at UW-La Crosse to release, if requested, this form and its attachments to clinical facilities.

_____ _____

Student Name (printed) Date

_____

Student Name (signature)