University of Wisconsin-La Crosse Physician Assistant Program
Required Immunizations

Name:_____ Date of Birth: _____UW-La Crosse 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).

DISEASE	REQUIREMENTS	DATE COMPLETED
Hepatitis B	**Immunization** (3 doses) **AND** **Immune titer** (drawn within past 5 years) *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:_____ Hep. B dose #2:_____ Hep. B dose #3:_____ Hep. B Titer:_____ ☐ Pos/immune ☐ Neg/not immune
MMR (Measles (Rubeola), Mumps, Rubella (German Measles))	**Immunization** (2 doses)	MMR vaccine dates: Dose #1:_____ Dose #2:_____
Polio	**At least 3 doses of polio vaccine required**	Type of vaccine:_____ Polio vaccine dates:
Tetanus/Diphtheria/Pertussis	**Immunization** (at least 2 doses; at least 1 TDAP) **AND** **evidence of TD booster within last 10 years**	Vaccine dates: TD Booster within last 10 years:
Varicella (Chicken Pox)	**Immunization** (2 doses) **OR** **Immune titer**	Varicella dose #1: _____ Varicella dose #2: _____ OR Varicella Titer:_____ ☐ Pos/immune ☐ Neg/not immune
Tuberculosis (TB)	Must be TB skin test dated within past 12 months Chest x-ray within last 12 months required if result is positive	Date applied:_____ Date read:_____ Result: ☐ Pos ☐ Neg Positive result: Chest x-ray within last 12 months: _____ _____

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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)