Immunization Instructions

The University of Michigan School of Dentistry requires all incoming DDS students to have completed a Record of Required Immunizations form. As a health professions student, you are in close contact with patients and other health care providers and can be exposed to a number of diseases. Thus, we require students to demonstrate protection and immunity by completion of the attached form.

Please complete and return the Record of Required Immunizations form no later than January 25, 2016.

Staff members of the Office of Admissions are not trained to read or review medical lab reports. Please DO NOT send your lab reports to our office.

REQUIRED IMMUNIZATIONS

A. Hepatitis B Vaccination
   • In addition to the Hepatitis B vaccination series, all students MUST have the Hepatitis B Immune Titer. If your test results for the titer are negative then you must receive a Hepatitis B Booster and a repeat Titer to show immunity.

B. Measles, Mumps, and Rubella
   • Students need two documented doses of the MMR vaccine.

C. Tuberculosis
   • Students are required to have a PPD skin test dated January 1, 2015 or later. If you test positive then you are required you have a chest x-ray to confirm that your immune system is normal and that you do not have tuberculosis.

D. Varicella (Chicken Pox)
   • If you have had chicken pox then you are not required to have the immune titer. If you have not had chicken pox but have received the Varicella Vaccination, you MUST also have the Varicella Immune Titer.

E. Tetanus/Pertussis
   • All students must have the one-time booster for Tdap.

REMEMBER TO...
Have your Health Care Provider fill out your immunization form completely so it will be processed quickly. Additionally, please do not send us your lab reports. The admissions staff is not trained to review your medical lab reports.

WHO CAN YOU CONTACT FOR MORE INFORMATION?
If you have additional questions after reading the information above, you can call 734-763-3316 or email ddsadmissions@umich.edu
**Student MUST communicate any missing piece of the below sections to the Office of Admissions with a plan of action.**

### PART I - TO BE COMPLETED BY THE STUDENT

Name: ____________________________

Last Name: ____________________________  First Name: ____________________________  MI: ____________________________

Street Address: ____________________________

City: ____________________________  State: ____________________________  Zip: ____________________________

Phone: ____________________________  Date of Birth: ____________________________  Today's Date: ____________________________

### PART II - TO BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN OR HEALTH CARE FACILITY OFFICIAL (DO NOT SEND LAB REPORT)

#### Hepatitis B Series: (Three shot series)

Dates Administered ____________________________ (Month/Year) #1 ____________________________

.................................................................  a minimum of 30 days after Hepatitis #1____________ (Month/Year) #2 ____________________________

.................................................................  a minimum of 6 months after Hepatitis #1__________ (Month/Year) #3 ____________________________

*If titer is NEGATIVE, then a Booster is REQUIRED ____________________________

**Hepatitis B Surface Antibody Titer: (HEP B TITER REQUIRED AFTER SERIES)**

Result (circle one):  POSITIVE  NEGATIVE *

Titer Date (Month/Year) ____________________________

*If titer is NEGATIVE, then a Booster is REQUIRED ____________________________

**Hepatitis B Surface Antibody Titer: (HEP B TITER REQUIRED AFTER BOOSTER)**

Result (circle one):  POSITIVE  NEGATIVE  Titer Date (Month/Year) ____________________________

#### Measles, Mumps, and Rubella Series: (Two shot series)

Dates Administered ____________________________ (Month/Year) #1 ____________________________

.................................................................  a minimum of 6 months after Hepatitis #1__________ (Month/Year) #2 ____________________________

#### Tuberculosis:

PPD skin test dated January 1, 2015 or later (Tine test unacceptable)

Result (circle one):  POSITIVE *  NEGATIVE  Date (Month/Year) ____________________________

*If PPD Positive, a chest x-ray OR QuantiFERON-TB Gold test must be submitted

Chest x-ray (done after the skin test conversion or within one year) (symptom review for active TB required)

Date (Month/Year): ____________________________  Result (circle one):  POSITIVE  NEGATIVE  

Quanti FERON-TB Gold test

Date (Month/Year): ____________________________  Result (circle one):  POSITIVE  NEGATIVE 

#### Varicella (Chicken Pox):

Has patient had chicken pox? .................................................................  (circle one):  YES  NO *

*If NO, a Varicella Booster is required with a follow-up titer in 6-8 weeks

Titer Date (Month/Year) ____________________________  Result (circle one):  POSITIVE  NEGATIVE  

#### Tetanus/Pertussis:

One-time booster for Tdap ................................................................. (Month/Year) ____________________________

### HEALTH CARE PROVIDER

Name: ____________________________  Address: ____________________________

Printed ____________________________

Signature: ____________________________  Phone: ____________________________

Send completed forms by January 25, 2016 to:

Email: ddsadmissions@umich.edu (Subject line: MATRICULATION FORMS)

Fax: 734-764-1922 (Attn: Admissions - Matriculation Forms)