Immunization Instructions

The University of Michigan School of Dentistry requires all incoming DDS students to have completed Record of Required Immunizations form. At the School of Dentistry campus students are in close quarters and can be exposed to a number of diseases. The health of our campus community is important to us all.

Please complete and return the Record of Required Immunizations form no later than January 19, 2015.

The Admissions staff at the School of Dentistry 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 repeat the Hepatitis B vaccination series.

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 April 1, 2013 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
RECORD OF REQUIRED IMMUNIZATIONS
(Must be completed/ returned by January 19, 2015)

PART I - TO BE COMPLETED BY THE STUDENT

Name: ______________________________
Last       First       MI

Street Address: ______________________________

City: ___________________________ State: ___________________________ Zip: ___________________________

Phone: ___________________________ Date of Birth: ___________________________ Today’s Date: ___________________________

**Student MUST communicate any missing piece of the below sections to the Office of Admissions with a plan of action

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 ___________________________
.........................., a minimum of 6 months after Hepatitis #1 ___________________________

Hepatitis B Surface Antibody Titer: (HEP B TITER REQUIRED AFTER SERIES)
Result (circle one): POSITIVE NEGATIVE *
Titer Date (Month/Year): ___________________________

*If titer is NEGATIVE, repeat the Hepatitis B series and follow-up with a repeat titer in 6-8 weeks

Measles, Mumps, and Rubella Series: (Two shot series)
Dates Administered: ___________________________ (Month/Year) #1 ___________________________
..........................

Measles, Mumps, and Rubella Series: (Two shot series)
Dates Administered: ___________________________ (Month/Year) #2 ___________________________
..........................

Tuberculosis:
PPD skin test dated January 1, 2014 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? YES NO *
Titer Date (Month/Year): ___________________________ Result (circle one): POSITIVE NEGATIVE

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

Tetanus/Pertussis:
One-time booster for Tdap: ___________________________

HEALTH CARE PROVIDER

Name: ___________________________________________
Printed

Address: ___________________________________________

Signature: ___________________________________________
Phone: ___________________________________________