

UC Riverside, School of Medicine Policies and Procedures**Policy Title:** Vaccination and Immunization Requirements**Policy Number:** 950-03-018

Responsible Officer:	Vice Chancellor, Health Affairs & Dean, School of Medicine
Responsible Office:	Vice Chancellor & Dean's Office
Origination Date:	05/20/2013
Date of Revision:	10/24/2019
Scope:	The UCR School of Medicine (UCR SOM) will require that all students (UCR or visiting), support staff assigned to clinical areas, and clinical faculty members (including visiting faculty) provide the following documentation from UCR Health Services, Public Health clinics, or their personal physician for personal and public health protection, prior to initiating any interaction/contact with the UCR Health patient population.

I. Policy Summary:

The recommendations of the Association of American Medical Colleges, U.S.'s Advisory Committee on Immunization Practices (ACIP), and the Center for Disease Control for immunizations of adolescents and adults exposed to clinical care environments will be followed for UCR medical students, residents, faculty, recognized visiting students and visiting faculty, and clinical area support staff.

II. Definitions: (Not Applicable)

"Clinical faculty members" will be defined as those UCR faculty *credentialed* to see patients in clinical care settings [including both employed UCR-SOM faculty and UCR-SOM Volunteer or visiting faculty assigned to patient care activities in a UCR Health clinical facility.]

III. Policy Text:**A. Immunization Requirements**

1. Immunization requirements include the following:
 - a. Positive hepatitis B antibody test
 - b. Demonstration of immunity to varicella (chickenpox), tetanus, diphtheria, rubella, measles and mumps
 - c. Re-immunization with measles, mumps, and rubella if the primary immunization occurred prior to 1980
 - d. Proof of a tetanus/diphtheria/pertussis booster within the last (5) years (a cellular pertussis ("ap") toxoid vaccine with the tetanus/diphtheria booster (Tdap) is strongly recommended)
 - e. All students and faculty must be monitored annually for tuberculosis during all years, and to assure their individual Tdap booster remains up to date within 5 years
 - f. If the tuberculosis skin test is positive, the individual's physician or Campus Health Center will evaluate for evidence of infection and need for therapy
 - g. Proof of annual flu vaccination. The following documents are acceptable and must contain the individual's name, the location of the vaccination provider, the

name of the vaccine and the date administered. Failure to provide at least 1 of the below requirements will result in disciplinary action:

- i. A letterhead note or script with your doctor's signature
- ii. An updated yellow vaccination card or vaccination record from your doctor's office
- iii. A receipt or signed document as proof of flu vaccine administration from a pharmacist or outside vendor
- iv. If an individual declines to obtain a flu vaccine, a written and signed consent is required to reflect the decision of declination by submitting the UCR SOM Informed Declination form (Exhibit C) to his or her respective unit for inclusion in their personnel file.

IV. Responsibilities: (Not Applicable)

V. Procedures:

A. Initial Immunization Confirmation (I-IC)

1. Each respective unit within the UC Riverside School of Medicine (Academic Affairs, Human Resources and Student Affairs) will provide to the successful candidate (faculty, staff or student) who is assigned to clinical areas the "UCR SOM I-IC" (Exhibit A) to be completed by their physician and returned prior to initiating any interaction/contact with UCR Health patient population.
2. This completed UCR SOM Immunization Confirmation document will become part of the employee/student personnel file and available for audit upon request.

B. Annual Immunization Confirmation (Annual-IC) (Beyond the initial year)

1. It will be the responsibility of the staff member, clinical faculty member or student to assure that their immunizations remain current however, each respective unit within the UC Riverside School of Medicine (Academic Affairs, Human Resources and Student Affairs) will review the Immunization Confirmation documents annually and notify the respective staff member, faculty member or student to update their immunizations and provide the updated confirmation to the respective unit for inclusion in their personnel file. "Annual- IC" (Exhibit B)
2. Annual Immunization Confirmation will include:
 - a. Tuberculosis skin test and/or screening for TB symptoms for known (+) TB skin test.
 - b. Confirmation that Tdap remains up-to-date within 5 years.
 - c. Annual flu shot at/or just before flu season; or,
 - d. Signed UCR SOM Informed Declination Form.

C. Exceptions

Individual exceptions to standard policy will be documented in a memo request and signed off by the Dean.

V. Forms/Instructions: (Refer to Exhibits)

VI. Contacts:

Unit	Senior Executive	Phone
SOM Administration	Vice Chancellor & Dean	951-827-4564
Faculty Affairs	Executive Dean	951-827-7793
Clinical Affairs	Senior Associated Dean, Clinical Affairs	951-827-7698
Financial & Operational Affairs	Senior Associate Dean, Finance and Administration	951-827-7681
Research Affairs	Senior Associate Dean, Academic Affairs and Research	951-827-5706
Student Affairs	Senior Associate Dean, Student Affairs	951-827-7671
Education	Senior Associate Dean, Education	951-827-7783
Compliance	Compliance and Privacy Officer	951-827-4672

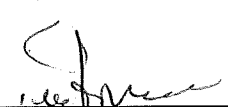
VIII. Related Information: (Not Applicable)

IX. Revision History:

Create Date: May 20, 2013

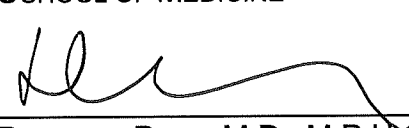
Revision Date: October 24, 2019

Approval(s):



 PAUL HACKMAN, J.D., L.L.M.
 CHIEF COMPLIANCE AND PRIVACY OFFICER,
 SCHOOL OF MEDICINE

10-24-2019
 DATE



 DEBORAH DEAS, M.D., M.P.H.
 VICE CHANCELLOR, HEALTH SCIENCES
 DEAN, SCHOOL OF MEDICINE

10/24/19
 DATE

Exhibit A**UCR School of Medicine
Initial—Immunization Confirmation (I-IC)****UCR-SOM policy for medical students, visiting students, faculty, and support staff
assigned any proportion of time *in patient care environments***

Health Screening Requirements: Immunization/Infectious Disease Status:

Name: _____ Student ID#: _____

Birth date: _____

1. **Measles Serology** (required for Measles [Rubeola])
Please specify the date and result of a blood test for Measles immunity. If the result is **negative**, you will need to get a booster vaccine and enter the date (which must be after the date of the blood test) in the immunization section below.
Test Date: _____ Result: _____ positive _____ negative
2. **Measles** (only required if Measles [Rubeola] titer is negative)
Please specify the date of your Measles immunizations.
Date for Dose 1: _____
3. **Rubella Serology** (required for Rubella)
Please specify the date and result of a blood test for Rubella immunity. If the result is **negative**, you will need to get a booster vaccine and enter the date (which must be after the date of the blood test) in the immunization section below.
Test Date: _____ Result: _____ positive _____ negative
4. **Rubella** (only required if Rubella titer is negative)
Please specify the date of your Rubella immunizations.
Date for Dose 1: _____
5. **Mumps Serology** (Required for Mumps)
Please specify the date and result of a blood test for Mumps immunity. If the result is **negative**, you will need to get a booster vaccine and enter the date (which must be after the date of the blood test) in the immunization section below.
Test Date: _____ Result: _____ positive _____ negative
6. **Mumps** (only required if Mumps titer is negative)
Please specify the date of your Mumps immunizations.
Date for Dose 1: _____
7. **Measles, Mumps, and Rubella (MMR)** (satisfied requirement for Measles, Mumps, and Rubella if any of the titers were negative)
Please specify the date of your MMR immunization.
Date for Dose 1: _____
8. **Diphtheria and Tetanus (Td or Tdap) Immunizations** (satisfies immunization requirement for Tetanus and Diphtheria)
Please indicate the date on which the dose was given:
Date for Dose 1: _____

9. **Varicella (Chicken Pox)** (satisfies Professional School Varicella Immunization requirement)
 If you received individual immunizations for Varicella, please indicate the date that each dose was given. Two doses required.
 Date for Dose 1: _____
 Date for Dose 2: _____
10. **Varicella Immunity** (satisfies Professional School Varicella Immunization requirement)
 If you had a blood test for Varicella, please provide the date and result:
 Test Date: _____ Result: _____ positive _____ negative
11. **Hepatitis B** (Professional School Hepatitis B Immunization requirement)
 Please indicate the date that each dose of Hepatitis B vaccine was given. Three doses required.
 Date for Dose 1: _____
 Date for Dose 2: _____
 Date for Dose 3: _____
12. **Hepatitis B** (satisfies Immunization Requirement for Hepatitis B. PLEASE NOTE: This is required IN ADDITION to Hepatitis B Immunization history)
 Please indicate the date and result of your Hepatitis B surface antibody titer.
 Test Date: _____ Result: _____ positive _____ negative
13. **PPD (Mantoux test for Tuberculosis)**
 If you had a PPD test for Tuberculosis, please record the result here.
 Date of Administration: _____
 Date Read: _____ Result: _____ positive _____ negative
 _____ mm Induration

1. Have you previously had a Tuberculin skin test (PPD)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. Do you have unintentional weight loss, fatigue, or loss of appetite?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3. Did you ever have a positive skin test?	<input type="checkbox"/> No <input type="checkbox"/> Yes
4. Have you received BCG (TB immunization) in the past? (If yes, date ___/___/___)	<input type="checkbox"/> No <input type="checkbox"/> Yes
5. Have you had MMR or Varicella vaccine within the last 60 days? (If yes, date (___/___/___))	<input type="checkbox"/> No <input type="checkbox"/> Yes
6. Do you have a persistent cough (lasting 3 weeks or more)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
7. Do you cough up blood?	<input type="checkbox"/> No <input type="checkbox"/> Yes
8. Do you have persistent, unexplained fevers or night sweats?	<input type="checkbox"/> No <input type="checkbox"/> Yes
9. Do you have a rash? If "Yes", for how long? _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
10. Do you have any reason to believe that your immune system may have been altered or damaged due to any of the following conditions or medications, which could increase your risk for tuberculosis (i.e. cancer; sarcoidosis; HIV/ AIDS; chemotherapy; chronic steroid therapy or medications to prevent transplant rejection)? Note: HIV infection and other medical conditions may cause a TB (PPD) skin test to be negative even when TB infection is present.	<input type="checkbox"/> No <input type="checkbox"/> Yes

14. **Chest X-ray** (for Tuberculosis screening)
 If you have had a chest x-ray performed as a follow-up to a positive PPD result, please record the result here:
 Date of Administration: _____ Result: _____ positive _____ negative

Infectious disease status reviewed and up to date _____ (check if complete)
 Signature of Clinician: _____ Date: _____
 Print Name and Title: _____ Telephone: _____

Address of Clinician: _____

Exhibit B

**UCR School of Medicine
Annual—Immunization Confirmation (Annual-IC)**

**UCR-SOM policy for medical students, visiting students, faculty, and support staff
assigned any proportion of time *in patient care environments***

Health Screening Requirements: Immunization/Infectious Disease Status:

Name: _____ Student ID#: _____

Birth date: _____

1. PPD (Mantoux test for Tuberculosis)

If you had a PPD test for Tuberculosis, please record the result here.

Date of Administration: _____

Date Read: _____ Result: _____ positive _____ negative
_____ mm Induration

1. Have you previously had a Tuberculin skin test (PPD)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. Do you have unintentional weight loss fatigue, or loss of appetite?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3. Did you ever have a positive skin test?	<input type="checkbox"/> No <input type="checkbox"/> Yes
4. Have you received BCG (TB immunization) in the past? (If yes, date ____/____/____)	<input type="checkbox"/> No <input type="checkbox"/> Yes
5. Have you had MMR or Varicella vaccine within the last 60 days? (If yes, date (____/____/____))	<input type="checkbox"/> No <input type="checkbox"/> Yes
6. Do you have a persistent cough (lasting 3 weeks or more)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
7. Do you cough up blood?	<input type="checkbox"/> No <input type="checkbox"/> Yes
8. Do you have persistent, unexplained fevers or night sweats?	<input type="checkbox"/> No <input type="checkbox"/> Yes
9. Do you have a rash? If "Yes", for how long? _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
10. Do you have any reason to believe that your immune system may have been altered or damaged due to any of the following conditions or medications, which could increase you risk for tuberculosis (i.e. cancer; sarcoidosis; HIV/ AIDS; chemotherapy; chronic steroid therapy or medications to prevent transplant rejection)? Note: HIV infection and other medical conditions may cause a TB (PPD) skin test to be negative even when TB infection is present.	<input type="checkbox"/> No <input type="checkbox"/> Yes

2. Chest X-ray (for Tuberculosis screening)

If you have had a chest x-ray performed as a follow-up to a positive PPD result, please record the result here:

Date of Administration: _____ Result: _____ positive _____ negative

3. Proof of annual flu vaccination

The following documents are acceptable and must contain the individual's name, the location of the vaccination provider, the name of the vaccine and the date administered. Failure to provide at least 1 of the below requirements will result in disciplinary action:

- i. A letterhead note or script with your doctor's signature
- ii. An updated yellow vaccination card or vaccination record from your doctor's

- office
- iii. A receipt or signed document as proof of flu vaccine administration from a pharmacist or outside vendor
- iv. If an individual declines to obtain a flu vaccine, a written and signed consent is required to reflect the decision of declination by submitting the UCR SOM Informed Declination form (Exhibit C) to his or her respective unit for inclusion in their personnel file.

Infectious disease status reviewed and up to date _____ (check if complete)

Signature of Clinician: _____ Date: _____

Print Name and Title: _____ Telephone: _____

Address of Clinician: _____

Exhibit C

**UCR School of Medicine
Informed Declination Form**

I DO NOT WANT A FLU SHOT.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease; on average, 36,000 Americans die every year from influenza-related causes.
- Influenza virus may be shed for up to 24 hours before symptoms begin, increasing the risk of transmission to others.
- Some people with influenza have no symptoms, increasing the risk of transmission to others.
- Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months. In California, influenza usually begins circulating in early January and continues through February or March.
- I understand that the influenza vaccine cannot transmit influenza and it does not prevent all disease.
- I have declined to receive the influenza vaccine for the season. I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention for all students and healthcare workers in order to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community.

Knowing these facts, I choose to decline vaccination at this time. I acknowledge that I have read this informed declination for Influenza Vaccination in its entirety and fully understand it.

Print Name: _____

Signature: _____

Date: _____