

# Randolph-Macon College

## Department of Physician Assistant Studies

### Immunization and Titer Entrance Requirements Due Prior to Matriculation

Last Updated: April 2025

Student Full Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Year Starting the PA Program: \_\_\_\_\_ Expected Graduation Year: \_\_\_\_\_

**Please note:** Please take any immunization records or prior documentation to your visit with a healthcare provider to complete this form. Immunization dates must be verified by a healthcare provider or via an immunization transcript from a medical office. This information will be added to this form by a healthcare provider after verification. Of note, no exemptions are accepted other than omission due to a medical contraindication or a documented allergy to a vaccine or its components.

Item	Required Immunizations, Titers, and Documentation	
Hepatitis B  <b>REQUIRED</b>	a. Proof of immunity to Hepatitis B via 3 documented vaccines  <b>AND</b>  b. Immune titer  <b>Please get the titer bloodwork done early!</b> If the titer results show "not immune", student will need to restart the hepatitis B vaccine series <b>AND</b> have repeat titers drawn. At a minimum, this process will take approximately 8-weeks.	Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____  <b>AND</b>  Titer Date ____/____/____ (REQUIRED) Titer Results: IMMUNE or NOT IMMUNE (circle one)  <b>IF</b> titers show "not immune": Restart vaccine series Dose 1 ____/____/____ Dose 2 ____/____/____  <b>AND</b>  Repeat Titer Date ____/____/____ (REQUIRED) Titer Results: IMMUNE or NOT IMMUNE (circle one)
MMR  <b>REQUIRED</b>	a. Two documented MMR vaccines  <b>AND/OR</b>  b. Immune titer	Dose 1 ____/____/____ Dose 2 ____/____/____  <b>AND/OR</b>  Titer Date ____/____/____ Titer Results: IMMUNE or NOT IMMUNE (circle one)

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Tuberculosis  <b>REQUIRED</b>	a. Negative TB/PPD skin test <u>OR</u> b. Negative chest x-ray <u>OR</u> c. QuantiFERON test  These results <b>must</b> be within the past 12 months.	Date placed ____/____/____ Date read ____/____/____ Result _____mm POS or NEG (circle one)  <u>OR</u> Date of Chest X-Ray ____/____/____ CXR Results POS or NEG (circle one)  <u>OR</u> Date of QuantiFERON test: ____/____/____  QuantiFERON Results: POS or NEG (circle one)
Tdap  <b>REQUIRED</b>	a. Tdap vaccine that was administered at age 18 or older <u>AND</u> b. Was within the last 10 years  Of note, Td is <b>not</b> an acceptable alternative in this situation.	Date of last dose ____/____/____
Varicella  <b>REQUIRED</b>	a. Two documented Varicella vaccines <u>OR</u> b. Immune titer	Dose 1 ____/____/____ Dose 2 ____/____/____  <u>OR</u> Titer Date ____/____/____ Titer Results: IMMUNE or NOT IMMUNE (circle one)
Influenza  <b>REQUIRED</b>	a. Documented dose for the current influenza season	Date of dose for current influenza season: ____/____/____
COVID-19  Initial series: <b>REQUIRED</b>  Current variant: RECOMMENDED	a. Documented initial vaccine series – either 2 doses of Moderna/Pfizer or 1 dose of J & J b. Documented vaccine for the current variant	<b>Required:</b> Dose 1 ____/____/____ Dose 2 ____/____/____  <b>Recommended, NOT required:</b> Date of dose for current variant: ____/____/____
Meningococcal  RECOMMENDED	a. Two documented MenACWY vaccines (one vaccine is sufficient if the first MenACWY vaccine was administered after 16 years	<b>Recommended, NOT required:</b> Dose 1 ____/____/____ Dose 2 ____/____/____  Dose 2 only needed if first vaccine was administered prior to 16 years of age

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