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: _____

		•	or prior documentation to your visit			
with a healthcare provider to complete this form. Immunization dates <u>must be verified</u> by a						
healthcare provider or via an immunization transcript from a medical office. This						
		-	re 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			ations, Titers, and Documentation			
Hepatitis B	a.	Proof of immunity to	Dose 1/			
		Hepatitis B via 3	Dose 2/			
REQUIRED		documented vaccines	Dose 3/			
		AND				
	b.	Immune titer	AND			
		Please get the titer bloodwork done early! If the titer results show "not immune", student will need to restart the hepatitis B vaccine series AND have repeat titers drawn. At a minimum, this process will take approximately 8-weeks.	Titer Date/(REQUIRED) Titer Results: IMMUNE or NOT IMMUNE (circle one) IF titers show "not immune": Restart vaccine series Dose 1/ Dose 2/ AND Repeat Titer Date/(REQUIRED) Titer Results: IMMUNE or NOT IMMUNE (circle one)			
MMR	a.	Two documented MMR	Dose 1/			
		vaccines	Dose 2/			
		AND/OR				
REQUIRED	b.	Immune titer	AND/OR			
			Titer Date//			

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Tuberculosis	a.	Negative TB/PPD skin test	Date placed/
		<u>OR</u>	Date read//
REQUIRED	b.	Negative chest x-ray	Result mm
		OR	POS or NEG (circle one)
	c.	QuantiFERON test	
		These results must be within	OR
		the past 12 months.	
		the past 12 months.	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	a.	Tdap vaccine that was	Date of last dose//
		administered at age 18 or	
REQUIRED		older	
	L	AND	
	b.	Was within the last 10 years	
		Of note, Td is <u>not</u> an	
		acceptable alternative in this	
		situation.	
Varicella	a.		Dose 1//
		vaccines	Dose 2//
REQUIRED	b.	<u>OR</u> Immune titer	OP
	D.	illilliane titel	<u>OR</u>
			Titer Date//
			Titer Results: IMMUNE or NOT IMMUNE (circle
			one)
Influenza	a.	Documented dose for the	
		current influenza	/
REQUIRED	-	season	
COVID-19	a.	Documented initial vaccine series – either 2 doses of	Required:
Initial as de-		Moderna/Pfizer or 1 dose of	Dose 1/
Initial series:		J&J	DOSE 2
REQUIRED	b.	Documented vaccine for the	Recommended, NOT required:
Current		current variant	Date of dose for current variant:
Current variant: RECOMMENDED			/ /
	_		
Meningococcal	a.		Recommended, NOT required:
		MenACWY vaccines (one	Dose 1/
RECOMMENDED		vaccine is sufficient if the	DU3C 2//
		first MenACWY vaccine was	Dose 2 only needed if first vaccine was administered
		administered after 16 years	prior to 16 years of age

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Polio	a. Proof of IPV vaccine series	Recommended, <u>NOT</u> required:
	a. Immune titer	Dose 1/
DECOMMENDED	a. Illillidile titel	Dose 3 / /
RECOMMENDED		Dose 4//
		Dose 5//
		Dose 5 is optional if person received a combination
		vaccine such as Pentacel, Pediarix, Kinrix, Vaxelis, or
		Quadracel)
		AND/OR
		Titer Date / /
		Titer Results IMMUNE or NOT IMMUNE (circle one)
Provider Name (pr	intad):	Credentials (MD,DO,NP,PA):
Provider Name (pr	inted)	Credentials (IVID,DO,NF,FA)
Provider Signature	:	Phone Number:
Provider Practice Ad	dress:	City:State:
(or official office sta	mp is acceptable)	
Deter		
Date:		
If an approved alte	rnate vaccination approach was	used or if the student has a medical
	true allergy to a vaccine or its co	
information with t	c.	
•	onsible for submitting this compl	•
	·	orm are included in MyMaconWeb (MMW) or at
https://rmc.medicate	connect.com/	
Stude	nt Legal Name:	Date of Birth: