International Observership for Education in Neurosciences: i-OPEN

Immunization Records

Health Requirements			
MMR (Measles, Mumps, Rubella) – *2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and one (1)dose of Rubella; OR serologic proof of immunity for Measles, Mumps, and/or Rubella*			
Option 1	**Vaccine**	**Date**	
MMR 2 doses of MMR vaccine	MMR Dose #1	____/____/____	❑ Copy Attached
	MMR Dose #2	____/____/____	❑ Copy Attached

Option 2	**Vaccine or Test**	**Date**	
Measles 2 doses of vaccine or positive serology	Measles Vaccine Dose #1	____/____/____	❑ Copy Attached
	Measles Vaccine Dose #2	____/____/____	❑ Copy Attached
	Serologic Immunity (IgG, antibodies, titer)	____/____/____	❑ Copy Attached
Mumps 2 doses of vaccine or positive serology	Mumps Vaccine Dose #1	____/____/____	❑ Copy Attached
	Mumps Vaccine Dose #2	____/____/____	❑ Copy Attached
	Serologic Immunity (IgG, antibodies, titer)	____/____/____	❑ Copy Attached
Rubella 1 dose of vaccine or positive serology	Rubella Vaccine	____/____/____	❑ Copy Attached
	Serologic Immunity (IgG, antibodies, titer)	____/____/____	❑ Copy Attached

Hepatitis B Vaccination – 3 doses of vaccine follow by a QUANTITATIVE Hepatitis B Surface Antibody (titer) preferably drawn 4-8 weeks after 3rd dose. If negative, give 4th (booster vaccine) and recheck Hepatitis B Surface Antibody (titer). If titer continues to be negative, complete second series (doses 5 and 6), and recheck Hepatitis B Surface Antibody (titer) again. If Hepatitis B Surface Antibody is negative after completing a second series (total of 6 doses of vaccine), additional testing including Hepatitis B Surface Antigen and Hepatitis B Core Antibody should be performed.

		Date	
Primary Hepatitis B Series	Hepatitis B Vaccine Dose #1	____/____/____	❑ Copy Attached
	Hepatitis B Vaccine Dose #1	____/____/____	❑ Copy Attached
	Hepatitis B Vaccine Dose #1	____/____/____	❑ Copy Attached
	QUANTITATIVE Hepatitis B Surface Antibody	____/____/____	Result: ____ mIU/ml ❑ Copy Attached
Booster Dose of Vaccine (if no response to primary series)	Hepatitis B Vaccine Dose #4	____/____/____	❑ Copy Attached
	QUANTITATIVE Hepatitis B Surface Antibody	____/____/____	Result: ____ mIU/ml ❑ Copy Attached
Completion of Second Series (if no response to Booster Dose)	Hepatitis B Vaccine Dose #5	____/____/____	❑ Copy Attached
	Hepatitis B Vaccine Dose #6	____/____/____	❑ Copy Attached
	QUANTITATIVE Hepatitis B Surface Antibody	____/____/____	Result: ____ mIU/ml ❑ Copy Attached
Hepatitis B Vaccine Non-responder (if Hepatitis B Surface Antibody negative after primary and secondary series	Hepatitis B Surface Antigen (if 3rd titer is negative)	Date: ____/____/____	Result: _____ ❑ Copy Attached
	Hepatitis B Core Antibody (if 3rd titer is negative)	Date: ____/____/____	Result: _____ ❑ Copy Attached
Chronic Active Hepatitis B	Hepatitis B Surface Antigen	Date: ____/____/____	Result: _____ ❑ Copy Attached
	Hepatitis B Viral Load	Date: ____/____/____	Result: _____ ❑ Copy Attached

Tuberculosis Surveillance – Complete Section A, B, OR C				
SECTION A: Negative Skin or Blood Test History - Last two skin tests or one IGRA required				
Option 1	Tuberculin Skin Test #1 (dated within 12 months of program start)	Date Placed	Date Read	Result: _____ mm ❑ Copy Attached
	Tuberculin Skin Test #2 (dated within 90 days of program start)	Date Placed	Date Read	Result: _____ mm ❑ Copy Attached
Option 2	Interferon gamma releasing assay (IGRA) Blood Test (dated within 90 days of program start)	Date		Result: _____ ❑ Copy Attached
SECTION B: History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test				
Option 1	Positive Tuberculin Skin Test	Date Placed	Date Read	Result: _____ mm
Option 2	Positive IGRA Blood Test	Date: ____ / ____ / ____		Result: _____ ❑ Copy Attached
	Chest X-ray (dated within 6 months of program start)	Date: ____ / ____ / ____		Result: _____ ❑ Copy Attached
	Written symptoms questionnaire (dated within 90 days of program start) – Form may be obtained from Internal Occupational Health	Date: ____ / ____ / ____		❑ Copy Attached
	Was prophylactic medication taken for latent TB?			❑ Yes ❑ No
	If prophylactic medication was taken, total duration of prophylaxis			_____ Months
SECTION C: History of Active Tuberculosis				
	Date of Diagnosis:			
	Date Treatment Completed:			
	Chest X-ray (dated within 6 months of program start)	Date: ____ / ____ / ____		Result: _____ ❑ Copy Attached
	Written symptoms questionnaire (dated within 90 days of program start) – Form may be obtained from Internal Occupational Health	Date: ____ / ____ / ____		❑ Copy Attached

Observer Signature

I certify that the information in this document and any attached documents are true, correct, and complete. I understand and agree that any misrepresentation, misstatement, or omission from this application, if discovered after Observer status has been awarded to me, may lead to termination of my participation in the Observer Experience.

Printed Name of Observer:	Date:
Signature of Observer	
Academic Institution / Year in School (if applicable):	
If under 18, signature of parent or legal guardian and relationship:	Date: