# UMMC Affiliated Student Health Form: Part A

Office of Academic Affiliations

Last Name:_____
First Name:_____
Date of Birth:_____/_____/_____
mm dd yyyy

The healthcare provider should verify all health/immunization requirements, complete, and sign the form.

**Measles Mumps and Rubella (MMR)**

2 MMR vaccines (or positive measles, rubella and mumps titers)

| 1ST Dose (mm/dd/yyyy) | 2nd Dose (mm/dd/yyyy) |
|---|---|
| | |

**OR TITER**

| Titer | Date of Titer (mm/dd/yyyy) | Titer Result (circle one) |
|---|---|---|
| Measles IgG Titer | | Positive or Negative |
| Rubella IgG Titer | | Positive or Negative |
| Mumps IgG Titer | | Positive or Negative |

**Varicella**

2 Varicella vaccines (or positive titer)

| 1ST Dose (mm/dd/yyyy) | 2nd Dose (mm/dd/yyyy) |
|---|---|
| | |

**OR TITER**

| Titer | Date of Titer (mm/dd/yyyy) | Titer Result (circle one) |
|---|---|---|
| Varicella IgG Titer | | Positive or Negative |

**Hepatitis B**

Hepatitis B vaccine 3-dose series (or 2-dose Heplisav-B series after 11/2017 for ages 18 and older) or positive Hepatitis B surface antibody titer or a UMMC declination statement. UMMC recommends Hepatitis B vaccine series and a positive antibody titer for optimal clinical safety.

| 1ST Dose (mm/dd/yyyy) | 2nd Dose (mm/dd/yyyy) | 3rd Dose (mm/dd/yyyy) |
|---|---|---|
| | | |
| Check one: ___3-dose series ___2-dose Heplisav-B series | | |

**OR TITER**

| Titer | Date of Titer (mm/dd/yyyy) | Titer Result (circle one) |
|---|---|---|
| HBSab Titer | | Positive or Negative or Equivocal |

**Tetanus, Diphtheria and Acellular Pertussis (Tdap)**

Tdap vaccine (tetanus, diphtheria and acellular pertussis) within 10 years (or Td booster within 10 years if prior dose of Tdap received after age 11 is greater than 10 years)

| | Dose (mm/dd/yyyy) |
|---|---|
| Tdap | |
| Td Booster (if applicable) | |

**Influenza (if applicable)**

Influenza vaccination during current influenza season (if placement occurs during flu season)

| | Dose (mm/dd/yyyy) |
|---|---|
| Influenza | |

**Healthcare Professional (Part A must be completed by MD, DO, PharmD, BSPharm, NP, PA, RN, or LPN):**

Signature:_____ Date:_____

Printed Name:_____ Phone Number:_____

Office/Facility/Company:_____ Address:_____

# UMMC Affiliated Student Health Form: Part B

Office of Academic Affiliations

Last Name:_____
First Name:_____
Date of Birth:_____/_____/_____
mm dd yyyy

The healthcare provider should verify all health/immunization requirements, complete, and sign the form.

## Tuberculosis (TB) Screening

| Condition | Requirement |
|---|---|
| No prior TB screening | Baseline TB blood test or 2-step TB skin test within 1-90 days prior to UMMC start date |
| Negative TB skin/blood test > 12 months | Repeat TB blood test or 2-step TB skin test within 1-90 days prior to UMMC start date |
| Prior negative TB baseline screening and TB skin/blood test within past 12 months | Annual repeat TB blood test or 1-step TB skin test |
| Previous positive TB skin/blood test | Healthcare provider reviews pulmonary history, chest X-ray, and evaluation/treatment record and verifies clearance on the UMMC Affiliated Student Health Form: Part B |

| **TB Skin Test** | Date Placed (mm/dd/yyyy) | Date Read (mm/dd/yyyy) | Results | Results (circle one) |
|---|---|---|---|---|
| Test #1 | | | ____mm | Positive or Negative |
| Test #2 | | | ____mm | Positive or Negative |

**OR**

| **TB Blood Test** | Date (mm/dd/yyyy) | Result (circle one) |
|---|---|---|
| TB IGRA Test (QuantiFERON Gold/ T-spot ) | | Positive or Negative |

**OR**

| **History of Positive TB Skin or Blood test? *** (circle one) | Date of Prior Positive Test (mm/dd/yyyy) | Date of Chest X-Ray (mm/dd/yyyy) | Prior Treatment Received? (circle one) | Cleared for clinical placement after review of pulmonary history and record of evaluation/treatment? (circle one) |
|---|---|---|---|---|
| Yes No | | | Yes No | Yes No |

**Healthcare Professional:**
***An MD, DO, NP, or PA must complete Part B if history of positive TB skin or blood test. If no prior positive test, Part B may be completed by MD, DO, PharmD, BSPharm, NP, PA, RN, or LPN.**

Signature:_____ Date:_____

Printed Name:_____ Phone Number:_____

Office/Facility/Company:_____ Address:_____