Dear School of Medicine Student,

It is a requirement of the School of Medicine that all incoming students fulfill health requirements PRIOR to entering the university. Student Health Services will verify your immunization records and tuberculosis testing.

Please read and follow the instructions below:

1. Print this assessment form and visit your health care provider to complete the form and perform all required vaccination(s)/blood tests/tuberculosis testing. Bring any vaccine records you may have with you to your visit. **NOTE:** the form must be signed by yourself AND your health care provider.

2. Sign onto your UCSD Electronic Health Record via Single Sign On: [https://shs.ucsd.edu](https://shs.ucsd.edu) (you need your Student PID & your UCSD email account).

3. Once you have signed on, click on Immunization Requirements only (you are not required to meet the University TB screening requirements, as the SOM Immunization Requirements form includes your tuberculosis testing).

4. Enter your immunizations/TB testing information into the online form and then UPLOAD or FAX the signed form and any laboratory or radiology results (details below). The preferred format is a single PDF document, but image files are acceptable.

5. Please clearly name your document as “SOM IMMUNIZATION REQUIREMENTS 2017” so it can be easily identified.

6. Select ONE method of transmitting your form, not both. (multiple submissions may delay your clearance):

   **UPLOAD:** Student Health Services Electronic Medical Record
   Student portal [https://shs.ucsd.edu](https://shs.ucsd.edu)

   **FAX:** 1-858-246-2414

Questions:

- If you have a medical question, please ask it through your UCSD Electronic Health Record: [https://shs.ucsd.edu](https://shs.ucsd.edu) “Ask a Nurse – Immunization Requirement”. Your UCSD must be established for us to respond to your message.

- If you are having technical problems uploading or faxing your form, email shsmr@ucsd.edu with your question and include your student ID number. Do not include any personal medical information as this is not a secure method of communication.

- The Student Health website has additional information on the health requirements: [https://wellness.ucsd.edu/studenthealth/health-requirements/Pages/default.aspx](https://wellness.ucsd.edu/studenthealth/health-requirements/Pages/default.aspx)

**CONFIRMATION OF RECEIPT OF YOUR DOCUMENT(S) IS NOT POSSIBLE.**

- Please check your UCSD email for a secure message from Student Health, as there may be a problem with your compliance or form and you may need additional vaccines or blood tests.

- When you log into your Student Health portal [https://shs.ucsd.edu](https://shs.ucsd.edu), click on your PROFILE and enter your **cell phone number and carrier** to receive message alerts via text.

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Do not upload this instruction page into your Electronic Health Record
**STUDENT ID:**  
**Name:**  
**Date of Birth:**  

<table>
<thead>
<tr>
<th>REQUIRED IMMUNIZATIONS</th>
<th>*NOTE: To achieve compliance ensure ALL vaccines are completed. PLEASE UPLOAD ALL LABORATORY RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TDAP VACCINE</strong></td>
<td></td>
</tr>
<tr>
<td>- Tetanus/Diphtheria</td>
<td>One dose adult Tdap on or after the age of 10 yrs or one dose in the last 10 yrs. If last Tdap is more than 10 yrs old, provide last date of Td and Tdap (required)</td>
</tr>
</tbody>
</table>
| WITH Pertussis (whooping cough) | Tdap Dose Date:  
|                                | Td Dose Date:  |

STUDENT AUTHORIZATION TO RELEASE INFORMATION  
I authorize UCSD Student Health Services to share information on this form to UCSD School of Medicine Student Affairs, for purposes of clinical placement requirements.

**STUDENT SIGNATURE:**  
**DATE:**  
**CELL Phone:**  

**To achi**  
**ve compliance ensure ALL vaccines are completed.**
<table>
<thead>
<tr>
<th>MMR VACCINE</th>
<th>YOU MUST HAVE 2 DOSES WITH THE FIRST DOSE GIVEN ON OR AFTER YOUR FIRST BIRTHDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Measles, Mumps &amp; Rubella</td>
<td>Dose 1 Date: __________ (must be on or after your 1st birthday)</td>
</tr>
<tr>
<td>- Two doses of MMR Vaccine OR</td>
<td>(Dose 1 &amp; 2 must be AT LEAST 28 days apart)</td>
</tr>
<tr>
<td>- Two doses of Measles, two doses of Mumps and one dose of Rubella OR</td>
<td>Dose 2 Date: __________</td>
</tr>
<tr>
<td>- Serologic proof of immunity to Measles, Mumps and Rubella</td>
<td>Dose 3 Date: __________ (*booster dose if titer negative)</td>
</tr>
<tr>
<td></td>
<td>(Dose 3 &amp; 4 must be AT LEAST 28 days apart)</td>
</tr>
<tr>
<td></td>
<td>Dose 4 Date: __________ (*booster dose if titer negative)</td>
</tr>
</tbody>
</table>

IF UNABLE TO PROVIDE PROOF OF VACCINATION YOU CAN OBTAIN A BLOOD TEST (TITER)

MEASLES – 2 doses of vaccine OR positive serology
POSTIVE Measles IgG Antibody Titer
Titer Date: __________ (only a positive titer meets the requirement)
Measles Dose 1 Date: __________
Measles Dose 2 Date: __________

MUMPS – 2 doses of vaccine OR positive serology
POSTIVE Mumps IgG Antibody Titer
Titer Date: __________ (only a positive titer meets the requirement)
Mumps Dose 1 Date: __________
Mumps Dose 2 Date: __________

RUBELLA – 1 dose of vaccine or positive serology
POSTIVE Rubella IgG Antibody Titer
Titer Date: __________ (only a positive titer meets the requirement)
Rubella Dose 1 Date: __________

*If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer 4-6 weeks post vaccination. If titer is still negative, receive second dose of vaccine and repeat titer 4-6 weeks later. Vaccine doses must be at least 28 days apart.
**VARICELLA (CHICKEN POX) VACCINE**
- Two doses of vaccine
  OR
- Positive Serology

YOU MUST HAVE 2 DOSES WITH THE FIRST DOSE ON OR AFTER YOUR 1ST BIRTHDAY

Dose 1 Date: ____________
Dose 2 Date: ____________
Dose 3 Date: ____________ (booster dose if your first dose was before your 1st birthday)

IF UNABLE TO PROVIDE PROOF OF VACCINATION OR IF YOU HAD THE DISEASE AS A CHILD, YOU CAN OBTAIN A BLOOD TEST (TITER)

POSITIVE Varicella IgG Antibody Titer
Titer Date: ____________

*If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer 4-6 weeks post vaccination. If titer is still negative, receive second dose of vaccine and repeat titer 4-6 weeks later. Vaccine doses must be at least 28 days apart.*

**HEPATITIS B VACCINES**

Dose 1 Date: ____________
Dose 2 Date: ____________
Dose 3 Date: ____________

POSITIVE Hepatitis B IgG Antibody Titer
Titer Date: ____________ (only a positive titer meets requirement)

If Hepatitis B Surface Antibody is negative after a full primary series, REPEAT Hepatitis B series

Dose 4 Date: ____________
Dose 5 Date: ____________
Dose 6 Date: ____________

POSITIVE Hepatitis B IgG Antibody Titer
Titer Date: ____________ (only a positive titer meets requirement)

**Additional Hepatitis B Testing**
- Required if a history of Hepatitis B Infection
  OR
- Negative Hepatitis B Surface Antibody after 2 primary series of Hepatitis B Vaccine
  OR
- Chronic active Hepatitis B

**Hepatitis B Core Antibody Titer**
Titer Date: ____________

**Hepatitis B Surface Antigen Titer**
Titer Date: ____________

**MENINGOCOCCAL VACCINE**
- MCV4/MPLSv4 or equivalent for students 21 yrs or younger

THE MOST RECENT DOSE MUST BE ON OR AFTER THE 16TH BIRTHDAY

Dose 1 Date: ____________
Dose 2 Date: ____________
(Booster dose if dose 2 was PRIOR to the 16th birthday)
Dose 3 Date: ____________
<table>
<thead>
<tr>
<th>TUBERCULOSIS SCREENING</th>
<th>REQUIRED DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td>IGRA/QUANTIFERON Testing</td>
<td>Testing must be performed within 6 months of entry to school (upload your Quantiferon result)</td>
</tr>
<tr>
<td></td>
<td>IGRA/QUANTIFERON TESTING DATE: ________</td>
</tr>
<tr>
<td></td>
<td>ONLY A NEGATIVE TEST MEETS REQUIREMENTS; IF POSITIVE PROCEED BELOW</td>
</tr>
<tr>
<td>History of a positive IGRA/Quantiferon OR</td>
<td>Chest X-Ray REQUIRED within 6 months of entry to school</td>
</tr>
<tr>
<td>Latent Tuberculosis (LTBI)</td>
<td>CHEST X-RAY DATE: ________</td>
</tr>
<tr>
<td></td>
<td>RESULT: ________(upload the radiology report)</td>
</tr>
<tr>
<td></td>
<td>Treatment for Latent TB</td>
</tr>
<tr>
<td></td>
<td>(LTBI): Medication: ______</td>
</tr>
<tr>
<td></td>
<td>Date of Treatment Completion: ______</td>
</tr>
<tr>
<td>History of Active Tuberculosis</td>
<td>Date of Diagnosis: ______</td>
</tr>
<tr>
<td></td>
<td>Date of Treatment Completion: ______</td>
</tr>
<tr>
<td></td>
<td>Date of Last Annual TB Symptom questionnaire: ______</td>
</tr>
<tr>
<td></td>
<td>Date of Last Chest X-ray: ______</td>
</tr>
<tr>
<td></td>
<td>Result: ________(upload the radiology report)</td>
</tr>
</tbody>
</table>

I attest that all dates and immunizations listed on this form are correct and accurate.

Provider’s Signature: ________________________________ Date: ________________________________
Physician, Nurse Practitioner, Physicians Assistant

Provider’s name printed: ________________________________ Phone number: ________________________________
Physician, Nurse Practitioner, Physicians Assistant

PROVIDERS/PRACTICE STAMP: