UNIVERSITY OF CALIFORNIA SAN DIEGO, SCHOOL OF MEDICINE
ADMISSION HEALTH REQUIREMENTS 2017-2018

Student ID:	Date of Birth: (MM/DD/YYYY)	Name: First Last

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 NUMBER:_____

Immunization/TB Screening Categories	**Required Data** **PLEASE UPLOAD ALL LABORATORY RESULTS**
Tdap (tetanus, diphtheria, pertussis)	**One (1) adult Tdap (after the age of 10). If last Tdap is more than 10yrs old, provide last date of Td and Tdap (required)** Tdap Dose date: _____/____/_____ Td Dose date: _____/____/_____
Measles (Rubeola) **Mumps** **Rubella** Two (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.	**MMR Immunizations** Dose 1 date: _____/_____/_____ Dose 2 date: _____/_____/_____ Dose 3 date: _____/_____/_____ (*If titer negative) Dose 4 date: _____/_____/_____ (*If titer negative) **OR** **Measles – 2 doses of vaccine OR positive serology** **Positive Measles IgG Antibody titer** Titer Date: _____/_____/_____ **(a positive titer meets requirement)** **Measles Vaccine Dose x 2** Dose 1 date: _____/_____/_____ Dose 2 date: _____/_____/_____ **Positive Mumps IgG Antibody titer** Titer Date _____/_____/_____ **(a positive titer meets requirement)** **Mumps Vaccine Doses x 2** Dose 1 date: _____/_____/_____ Dose 2 date: _____/_____/_____ **Positive Rubella IgG Antibody titer** Titer Date _____/_____/_____ **(a positive titer meets requirement)** **Rubella Vaccine Doses x 2** Dose 1 date: _____/_____/_____ Dose 2 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 a second dose of vaccine and repeat titer 4-6 weeks later. Vaccine doses must be at least 28 days apart.

Varicella (chicken pox) Two doses of vaccine **OR** positive serology	**Positive Varicella IgG Antibody titer (required)** Titer Date _____/_____/_____ **(only a positive titer meets requirement)** **OR** **Varicella Immunizations** Dose 1 date: _____/_____/_____ Dose 2 date: _____/_____/_____ Please check titer first before receiving vaccine *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 3 doses of vaccine followed by a Quantitative Hep B Surface Antibody (titer) preferably drawn 4-8 wks after 3rd dose. If negative, complete a second Hep B series followed by a repeat titer. If Hep B Surface antibody is negative after secondary series, additional testing including Hep B Surface Antigen should be performed. Please see http://www.cdc.gov/mmwr/pdf/rr/rr6103.pdf for more information.	**Hepatitis B Immunizations (required)** Dose 1 date: _____/_____/_____ Dose 2 date: _____/_____/_____ Dose 3 date: _____/_____/_____ **Positive Hepatitis B Surface Antibody titer (required) QUANTITATIVE** Titer Date: _____/_____/_____**(only a positive titer meets requirement)** **If Hepatitis B Surface Antibody negative after a full a full primary series, repeat Hepatitis B series** Dose 4 date: _____/_____/_____ Dose 5 date: _____/_____/_____ Dose 6 date: _____/_____/_____ **Positive Hepatitis B Surface Antibody titer (required) QUANTITATIVE** Titer Date: _____/_____/_____ **(only a positive titer meets requirement)**
Required if a history of Hep B infection **OR** **Negative Hep B surface antibody** after 2 primary series of Hep B vaccine **OR** **chronic active Hep B**.	**Hepatitis B Core Antibody titer** Titer Date: _____/_____/_____ **Hepatitis B Surface Antigen titer** Titer Date: _____/_____/_____
Meningococcal Conjugate (MCV4) 1 dose on or after age 16 for all students up to the age of **22yrs or younger**	Dose Date_____/_____/_____

TUBERCULOSIS SCREENING	Required Data PLEASE UPLOAD ALL LABORATORY RESULTS
Quantiferon Testing	**Testing must be performed within 6 months of entry to school.** **(please upload all laboratory results)** REQUIRED: QuantiFERON testing: Test Date: _____/_____/_____ (only a negative test meets requirement, if positive proceed below)
History of a POSITIVE QUANTIFERON **OR** Latent TB	**Chest Xray REQUIRED within 6 months of entry to school.** **CHEST XRAY**: Test date: _____/_____/_____ Result_____ (Please upload radiology report) **Treatment for Latent TB:** Medication:_____ Dates of Treatment:_____
History of Active Tuberculosis	Date of Diagnosis: _____/_____/_____ Date of Treatment Completed: _____/_____/_____ Date of Last Annual TB Symptom Questionnaire: _____/_____/_____ Date of Last Chest X-ray: _____/_____/_____

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

Provider's Signature: _____**Date:** _____
Physician, Nurse Practitioner, Physicians Assistant, or RN

Provider's name printed: _____**Phone number**: _____
Physician, Nurse Pracitioner, Physicians Assistant, or RN

PROVIDERS/PRACTICE STAMP:

INSTRUCTIONS

1. **Gather all relevant vaccine history, TB testing, receive vaccines and/or titers and have your health provider fill out this form and sign it.**
2. **Enter this information into the Student Health Services electronic health record https://shs.ucsd.edu**
3. **Upload this form and ALL assosciated laboratory/radiology records into your health record using the following methods: (Please identify your documents as being for the School of Medicine health requirements)**

Upload (Preferred Method) pdf OR Image file	**Fax**
https://shs.ucsd.edu	**1-858-246-2414**
Student Electronic Health Record/Student Health Portal	(please submit by upload OR fax, not both)

4. **Any questions please utilize the "Ask-A-Nurse" in the electronic health record.**
5. **Please check your ucsd email for alerts as to messages from Student Health Services.**