UC Davis School of Medicine Health Requirements

All medical students must have the following immunization and infectious disease/immunity screening performed **before** attendance at UCD SOM. This form must be completed by your health care provider.

STUDENT NAME (Please print): _____

Please see "Incoming Student Health Requirements Factsheet 2021" for detailed instructions

1. Proof of Immunity - Please enter DATES for the following:

Positive Measles Titer: _____ (Date) **OR** **MMR/Measles Vaccines:** #1: _____ (Date) #2: _____ (Date)

Positive Mumps Titer: _____ (Date) **OR** **MMR/Mumps Vaccines:** #1: _____ (Date) #2: _____ (Date)

Positive Rubella Titer: _____ (Date) **OR** **MMR/Rubella Vaccines:** #1: _____ (Date) #2: _____ (Date)

Positive Varicella Titer: _____ (Date) **OR** **Varicella (Chicken Pox) Vaccines:** #1: _____ (Date) #2: _____ (Date)

Positive Quantitative Hepatitis B Surface Antibody Titer: _____ (Date) _____ (Value) **(see Note)**

Hepatitis B Vaccines: #1: _____ (Date) #2: _____ (Date) #3: _____ (Date)

Note: The vaccination series ALONE is not sufficient. A Hepatitis B Surface Antibody Quantitative number value ≥12 is required, not a DNA – PCR. ONLY a Quantitative Hepatitis B titer will be accepted.

Negative Hepatitis C Titer Date: _____

T-dap Vaccination Date: _____

Tuberculosis: What was the result of your last tuberculosis screening? The tuberculosis screening is annual.

1st PPD Placed Date: _____ Read Date: _____mm induration _____ ☐ positive ☐ negative

2nd PPD Placed Date: _____ Read Date: _____mm induration _____ ☐ positive ☐ negative

OR

Quantiferon Date: _____ **Result** ☐ positive ☐ negative

Chest X-Ray: In case of a positive tuberculosis screening, chest X-ray must be 3 months of start date. It is a confirmation to rule out active Tuberculosis disease.

Date: _____ Result: _____ Institution: _____

Were you treated? _____ How long were you treated? _____ Institution: _____

I verify that the above information is accurate and true. (Please provide facility stamp below)

Name/Title: _____

Signature: _____

License #: _____

State/Country: _____

Phone#: _____

E-mail Address: _____

Date: _____

Place Facility Stamp Here

For specific instructions please see "Incoming Student Health Requirements Factsheet 2021":
http://www.ucdmc.ucdavis.edu/mdprogram/registrar/classinfo.html 3/28/2017