UCDAVIS HEALTH | SCHOOL OF MEDICINE
Registrar's Office

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Student Health Clearance Form

Form must be signed by licensed medical provider to be valid. Services to be provided by a licensed medical provider (ex. Primary Care Physician). In lieu of this form, you may provide lab reports of your immunizations. You will upload your immunizations and/or this form to your myRecordtracker account.

Name: _____ / _____ / _____ Date of Birth: _____ / _____ / _____
Last First MI MM DD YYYY

REQUIRED IMMUNIZATION DOCUMENTATION FOR INFECTIOUS DISEASES CLEARANCE

TB Screening

Requirement: 1st PPD within the last 365 days and 2nd PPD or QuantiFERON within 90 days prior to start date.

**For positive PPD or QuantiFERON test, a chest x-ray is required within 90 days prior to start date (step C)

A. QuantiFERON (Preferred): Test Date: _____ /_____ /_____ Results: _____
Date of Annual TB Symptoms Interview: _____ /_____ /_____ ☐ Neg ☐ Pos
History of BCG Vaccination: ☐ Yes ☐ No (BCG is a vaccine given to those born outside the US.)

B. Two-step Tuberculin Intermediate Skin Test (PPD):
Test 1 Date: _____ /_____ /_____ Reading: _____ /_____ /_____ Results:____MM Induration: ☐ Neg ☐ Pos
Test 2 Date: _____ /_____ /_____ Reading: _____ /_____ /_____ Results:____MM Induration: ☐ Neg ☐ Pos

C. Chest X-ray: Date: _____ /_____ /_____ Results: _____ TB Symptoms: ☐ Neg ☐ Pos
History of Treatment: ☐ Yes ☐ No If yes, Date: _____ /_____ /_____ How many months?:_____

MMR or Individual Measles, Mumps and Rubella

Requirement: Two immunization dates (dated at least 28 days apart) OR positive titer

A. MMR Vaccines: 1. _____ /_____ /_____ 2. _____ /_____ /_____
OR
B. Individual Measles, Mumps and Rubella Vaccines:
Measles: 1. _____ /_____ /_____ 2. _____ /_____ /_____ **OR** Titer Date: _____ /_____ /_____ ☐ Neg ☐ Pos
Mumps: 1. _____ /_____ /_____ 2. _____ /_____ /_____ **OR** Titer Date: _____ /_____ /_____ ☐ Neg ☐ Pos
Rubella: 1. _____ /_____ /_____ **OR** Titer Date: _____ /_____ /_____ ☐ Neg ☐ Pos

Varicella Vaccine (chicken pox)

Requirement: Two vaccination dates (28 days apart) OR positive titer

Varicella Vaccines: 1. _____ /_____/_____ 2. _____ /_____ /_____ **OR** Titer Date: _____ /_____ /_____ ☐ Neg ☐ Pos

Tdap Vaccine (tetanus, diphtheria, pertussis) must be within last 10 years

Tdap Vaccine**:** 1. _____ /_____ /_____

Hepatitis B and C (Hep C is Recommended)

Requirement: Hepatitis B titer and vaccine series required. *Numeric value is required, must be quantitative.

A. Hepatitis B: Surface Antibody Titer Date: _____ /_____ /_____ *Numeric Value: _____ mIU/ml ☐ Neg ☐ Pos
Hepatitis B Injection Dates: 1. _____ /_____ /_____ 2. _____ /_____ /_____ 3. _____ /_____/_____
HEPLISAV-B Injection Dates: 1. _____ /_____/_____ 2. _____ /_____ /_____
B. Hepatitis C (Recommended): Surface Antibody Titer Date: _____ /_____ /_____ Results: _____

All information below (including stamp) is required. Incomplete forms will not be accepted.

I verify that the health requirement information provided is accurate and true.

Primary care physician's name: _____ Date: _____

PCP signature: _____ PCP Business Stamp:

Dates added after PCP signature will not be accepted. Instead, complete a new form or upload lab results to your MyRecordTracker.