UCDAVIS HEALTH | SCHOOL OF MEDICINE
Registrar's Office

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Health Clearance Form

This form must be completed by your health care provider.

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. 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**

B. QuantiFERON: Test Date: _____ /_____ /_____ ☐ Neg ☐ Pos**

History of BCG Vaccination: ☐ Yes ☐ No
(BCG is a vaccine given to those born outside the US.)

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)

Tdap Vaccine: 1. _____ /_____ /_____

Hepatitis B and C (Hep C is Recommended)

A. Hepatitis B*: Surface Antibody Titer Date: _____ /_____ /_____ Numeric Value: _____ mIU/ml ☐ Neg ☐ Pos

Hepatitis B Injection Dates: 1. _____ /_____ /_____ 2. _____ /_____ /_____ 3. _____ /_____ /_____

B. Hepatitis C (Recommended): Surface Antibody Titer Date: _____ /_____ /_____ Results: _____

*Requirement: 3 injections with a follow up positive titer. Titer must show numerical value or description of what a positive result is. If titer is negative repeat series and titer required.

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

Primary care physician's name: _____ Date: _____

PCP signature: _____ PCP Business Stamp: