UC DAVIS HEALTH | SCHOOL OF MEDICINE

Registrar's Office

4610 X Street, Suite 1208, Sacramento, CA 95817
Tel: 916-734-4027 | Fax: 916-734-2178
hs-studentrecords@ucdavis.edu

Student Health Clearance Form

This form must be completed by your health care provider. 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.