UMMC Affiliated Student Health Form: Part A

UMMC Office of Academic Affiliations

Last Name:_____
First Name:_____
Date of Birth:_____/_____/_____
mm dd yyyy

The healthcare provider should verify all health/immunization requirements, complete, and sign the form.

COVID-19

Full COVID-19 series

Manufacturer/Lot Number	1st Dose (mm/dd/yyyy)	2nd Dose (mm/dd/yyyy)

Measles Mumps and Rubella (MMR)

2 MMR vaccines (or positive measles, rubella and mumps titers)

1ST Dose (mm/dd/yyyy)	2nd Dose (mm/dd/yyyy)

OR TITER

Titer	Date of Titer (mm/dd/yyyy)	Titer Result (circle one)
Measles IgG Titer		Positive or Negative
Rubella IgG Titer		Positive or Negative
Mumps IgG Titer		Positive or Negative

Varicella

2 Varicella vaccines (or positive titer)

1ST Dose (mm/dd/yyyy)	2nd Dose (mm/dd/yyyy)

OR TITER

Titer	Date of Titer (mm/dd/yyyy)	Titer Result (circle one)
Varicella IgG Titer		Positive or Negative

Tetanus, Diphtheria and Acellular Pertussis (Tdap)

Tdap vaccine (tetanus, diphtheria and acellular pertussis) within 10 years (or Td booster within 10 years if prior dose of Tdap received after age 11 is greater than 10 years)

	Dose (mm/dd/yyyy)
Tdap	
Td Booster (if applicable)	

Influenza (if applicable)

Influenza vaccination during current influenza season (if placement occurs during flu season)

Dose (mm/dd/yyyy)

Hepatitis B

Hepatitis B vaccine 3-dose series (or 2-dose Heplisav-B series after 11/2017 for ages 18 and older) or positive Hepatitis B surface antibody titer or a UMMC declination statement. UMMC recommends Hepatitis B vaccine series and a positive antibody titer for optimal clinical safety.

1ST Dose (mm/dd/yyyy)	2nd Dose (mm/dd/yyyy)	3rd Dose (mm/dd/yyyy)
Check one: ___3-dose series ___2-dose Heplisav-B series		

OR TITER

Titer	Date of Titer (mm/dd/yyyy)	Titer Result (circle one)
HBSab Titer		Positive or Negative or Equivocal

Healthcare Professional (Part A must be completed by MD, DO, PharmD, BSPharm, NP, PA, RN, or LPN):

Signature:_____ Date:_____

Printed Name:_____ Phone Number:_____

Office/Facility/Company:_____ Address:_____

UMMC Affiliated Student Health Form: Part B

Office of Academic Affiliations

Last Name:_____
First Name:_____
Date of Birth:_____/_____/_____
mm dd yyyy

The healthcare provider should verify all health/immunization requirements, complete, and sign the form.

Tuberculosis (TB) Screening

Condition	Requirement
No prior TB screening	Baseline TB blood test or 2-step TB skin test within 1-90 days prior to UMMC start date
Negative TB skin/blood test > 12 months	Repeat TB blood test or 2-step TB skin test within 1-90 days prior to UMMC start date
Prior negative TB baseline screening and TB skin/blood test within past 12 months	Annual repeat TB blood test or 1-step TB skin test
Previous positive TB skin/blood test	Healthcare provider reviews pulmonary history, chest X-ray, and evaluation/treatment record and verifies clearance on the UMMC Affiliated Student Health Form: Part B

TB Skin Test	Date Placed (mm/dd/yyyy)	Date Read (mm/dd/yyyy)	Results	Results (circle one)
Test #1			____mm	Positive or Negative
Test #2			____mm	Positive or Negative

OR

TB Blood Test	Date (mm/dd/yyyy)	Result (circle one)
TB IGRA Test (QuantiFERON Gold/ T-spot)		Positive or Negative

OR

History of Positive TB Skin or Blood test? * (circle one)	Date of Prior Positive Test (mm/dd/yyyy)	Date of Chest X-Ray (mm/dd/yyyy)	Prior Treatment Received? (circle one)	Cleared for clinical placement after review of pulmonary history and record of evaluation/treatment? (circle one)
Yes No			Yes No	Yes No

Healthcare Professional:

***An MD, DO, NP, or PA must complete Part B if history of positive TB skin or blood test. If no prior positive test, Part B may be completed by MD, DO, PharmD, BSPharm, NP, PA, RN, or LPN.**

Signature:_____ Date:_____

Printed Name:_____ Phone Number:_____

Office/Facility/Company:_____ Address:_____