University of Massachusetts
UMASS Medical School

Congratulations and welcome to the University of Massachusetts Worcester!
The following is a checklist for you to use as a guide as you complete the Student Health requirements.

All sections of the Health Clearance must be completed by your provider no later than 2 weeks prior to the start of school. Please complete this ASAP. If you do not meet health clearance requirements listed below you will be held from class or clinical experiences until it is complete. If you are missing any information an email will be sent to the e-mail address you list on the form.

The Health Clearance forms may also be downloaded for your convenience from the Student Health Services (SHS) website www.umassmed.edu/studenthealth. Please check that your provider has filled in the information clearly and completely **on the health clearance form** and has provided the necessary supporting documentation.

Please note: A copy of the lab reports for all titers must be included with your forms. Also, any information provided in another language must be translated into ENGLISH.

STUDENT HEALTH CLEARANCE CHEKLIST

1. **Physical exam:** Within one year of school admission and signed by your provider. ☐

2. **MMR (Measles, Mumps, Rubella):** MMR vaccine dates (2 doses) **or** positive titers.
   (**Please Note**: If measles, mumps or rubella titers are negative you must provide dates of 2 MMRs (month/ day/year)

   MMR #1 ☐ MMR #2 ☐ **or** Measles titer ☐ Mumps titer ☐ Rubella titer ☐

3. **Hepatitis B**: **D**ates of immunizations (3 doses) and Hepatitis B surface antibody titer (HBsAb)
   ** (**Please Note**: If you **do not** have a positive Hepatitis B surface antibody titer or if you have not completed the Hepatitis B series you are required to provide a Hepatitis B surface antigen titer (HBsAg)

   Hep B #1 ☐ Hep B # 2 ☐ Hep B #3 ☐ **and** positive HBsAb titer ☐ HBsAg ** ☐

4. **Varicella (Chicken pox):** Dates of Immunization (2 doses) **or** positive Varicella titer.

   Varicella #1 ☐ Varicella # 2 ☐ **or** positive Varicella titer ☐

5. **Tetanus Diptheria Pertussis**: A one-time Tdap is required. ☐

6. **2-Step Tuberculosis Skin Test (TST)**: **2-step** TST **or** Quantiferon Gold serology or T-Spot is required within 3 months before the start of school

   TST result #1 ☐ TST result #2 ☐ **or** Quanterferon Gold / T-Spot result ☐

Please refer to Health Clearance Form for specific TST requirements. 2-Step TST Information sheet also attached.

****NOTE:** If you have a history of a positive TST, date of positive result and documentation of treatment, if any, must be provided. In addition, **a copy of a chest x-ray report** taken after the positive TST must be attached. Also fill out the attached Symptom review, sign and date within 3 months prior to the start of school.

☐ **Chest X-ray report** ☐ **Treatment**

7. **Blood Borne Pathogen Policy**: Read and sign the Blood Borne Pathogen Policy and return with your packet. ☐

8. Recommended to provide childhood immunization series for polio and dTaP. ☐

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NAME: ____ **M**_____ **F**______
Last First Middle

ADDRESS: ____
Street City State Zip

TELEPHONE: ____________________ **EMAIL:** ____________________

DOB: ____________________ **ENTRANCE YEAR:** ____________________

SCHOOL: Please circle one GSBS

1. Date of Last Physical: (**MUST** be within 1 year of school admission) ____________________
Month/Day/Year

2. MEASLES, MUMPS, RUBELLA (MMR): Provide MMR immunizations (2 doses) **<u>or</u>** positive titer results as proof of immunity. A copy of the titer reports **MUST** be attached. **(Please note: If any titer is negative, documentation of 2 doses of MMR are required.)**

MMR #1 ________________ (MM/DD/YYYY)
MMR #2 ________________ (MM/DD/YYYY)

Measles titer: _____________ (MM/DD/YYYY) Result: Positive ☐ Negative ☐
Rubella titer: _____________ (MM/DD/YYYY Result: Positive ☐ Negative ☐
Mumps titer: _____________ (MM/DD/YYYY) Result: Positive ☐ Negative ☐

Lab reports MUST be attached.

3. TETANUS DIPTHERIA PERTUSSIS (Tdap): A one- time Tdap **2006 or after** is **required**.

Tdap ______________________ (MM/DD/YYYY)

4. HEPATITIS B: Provide **<u>BOTH</u>** Hepatitis B immunization dates (3 doses)

Hep B #1 __________________ (MM/DD/YYYY)
Hep B #2 __________________ (MM/DD/YYYY)
Hep B #3 __________________ (MM/DD/YYYY)

5. VARICELLA (Chickenpox): Varicella Immunization (2 doses) **<u>or</u>** a positive Varicella Titer **(lab report MUST be attached).** Or History of chicken pox

Varicella #1: ________________ (MM/DD/YYYY)
Varicella #2: ________________ (MM/DD/YYYY)
Varicella Titer: _______________ (MM/DD/YYYY) Result: Positive ☐ Negative
Do you have a history of Varicella? Yes ☐ No ☐ If Yes, Date: __________

Last Name:___________________ First Name: __________________________ DOB: _____________________

6. 2- STEP TUBERCULIN SKIN TEST (TST): 2 step TST **or** Quantiferon Gold Serology or T-Spot result.

- **If you have no history of a 2-step TST,** you will need to complete two TST's (Ideally1-4 weeks apart), within 3 months prior to the start of school.
- **If you have had a 2-step in the past and have maintained annual TST testing since your 2 step** please provide this documentation – Only one TST is required to be completed within 3 months prior to the start of school.
- **If you have had a previous TST within the current year** only one TST is required to be completed within 3 months prior to the start of school. **Please be sure to provide documentation of both.**

TST #1 ______________(MM/DD/YYYY) Result: NEG ______ POS ______ mm ________ Quantiferon Gold/T-Spot result pos /neg
TST #2 ______________(MM/DD/YYYY) Result: NEG ______ POS ______ mm ________ (A**ttach lab report**)

If you have had a positive TST, a copy of a chest x-ray report after the positive result date must be submitted, and any subsequent treatment (i.e. INH)** **History of BCG Vaccine does not exempt you from completing the 2-stepTST. ** Also please fill out sign and date the attached Symptom Review questions within 3 months prior to the start of school.**

POSITIVE TEST RESULT: DATE: ______________ MM of induration ____ TREATMENT: YES ☐ NO ☐
IF YES, DATES OF TREATMENT: _____________________________HISTORY OF BCG VACCINE DATE: __________________
DATE OF CHEST X-RAY ______________ **Copy of the report MUST be attached.**

EXAMINER SIGNATURE: ___________________________________ DATE: ____
MD/ NP/ PA