MANDATORY HEALTH IMMUNIZATIONS

The UC Davis School of Medicine and the Permanente Medical Group requires that all active students remain current with the School’s required health immunizations for personal protection and community health reasons. And, per UCDH Hospital Policy, all students must meet current UCDH standards for healthcare professionals. The health clearance requirements include diagnostic tests; positive hepatitis B antibody test; and demonstration of immunity to rubella, rubeola, varicella and mumps. Costs associated with required testing and immunizations are the responsibility of the student.

1. Both MEASLES (RUBEOLA & RUBELLA) Criteria:
   1. Positive serology for antibody to both Rubeola & Rubella.
   2. Or, documentation of 1 Rubella and 2 Rubeola vaccinations (or 2 MMR’s) in lifetime.
   Everyone must show proof of immunity to both Rubeola & Rubella. Per UCDH Hospital Policy, all students must meet UCDH standards.

2. MUMPS Criteria:
   1. Positive serology
   2. Or, 2 recorded MMR’s
   3. Or, documented 2 mumps booster after a negative serology if no immunization records

3. VARICELLA (CHICKEN POX) Criteria:
   1. Positive serology for antibody to Varicella
   2. Or, documentation of two Varicella vaccines. Drawing titers is not recommended after vaccine.
   We do not accept the history of illness as a proof of immunity.

4. QUANTITATIVE HEPATITIS B Criteria:
   1. Positive serology for a quantitative surface antibody to Hepatitis B.
   2. Or, proof of having received 3 Hepatitis B vaccine injections if negative serology.

   After having received 3 vaccine injections, a new titer MUST be drawn.

   NOTE: Hepatitis B titer ≥12 IU ml is considered immune. ONLY a Quantitative Hepatitis B titer will be accepted. If the incorrect titer is drawn, a new titer will have to be completed.

   ***Students must show proof of having received all 3 Hepatitis B vaccines AND a positive quantitative surface antibody. The vaccination series ALONE is not sufficient. A Hepatitis B Surface Antibody Quantitative number value ≥12 IU ml is required. If your value is ≤11.9 IU ml, you must receive a Hepatitis B booster shot. ONLY a Quantitative Hepatitis B titer will be accepted. A result of “immune” or “not immune” will not be accepted.***
5. TUBERCULOSIS (TB) Criteria:
   Intradermal TB skin tests are annual.
   The criteria are:
   1. Evidence of PPD skin test results within the last 365 days of your start date (June 17, 2018) AND evidence of PPD skin test results within the last 90 days of the start of the program.
   Otherwise a 2-step PPD will be done (2nd test placement must be minimum 7 days after the read of the first test. Example: If 1st test was read on Wednesday then 2nd test can be placed next Wednesday the earliest, with the Friday read date.) The second step should be within 90 days of the start of the program.
   2. If a PPD result is Positive - Evidence of a chest x-ray within 90 days of the start of the program will be required.
   3. Negative Quantiferon lab test within 90 days of start date. If positive, see # 2 above. This test would replace a 2 step PPD.

   *** If you have not been receiving annual TB testing, you must complete the 2-step PPD, which takes a minimum of 12 days to complete. You may also complete a Quantiferon test within 90 days of the start of the program (June 17, 2018) in lieu of the 2-step PPD test.

   If you have previously tested positive for TB, you must provide the results of a chest x-ray within 90 days of the start of the program (June 17, 2018).***

6. HEPATITIS C Criteria:
   1. Negative antibody Hepatitis C titer (anti-HCV). Titer result must be within 90 days of the start of the program (June 17, 2018).
   2. If positive, please complete a viral load to ascertain disease & complete counseling on reverse transmission.
   3. Refer to PCP for any potential follow ups.

7. TDap (Tetanus, Diphtheria and Pertussis)

8. SEASONAL FLU VACCINE: Students must obtain their seasonal flu vaccination from their own primary care physician or some other outside source and provide documentation confirming that they have been vaccinated. UC Davis does not provide the flu vaccine to Prep Médico students.

PLEASE NOTE: The UC Davis School of Medicine Health Immunization Policy will be updated periodically to comply with national (CDC) and UCDH standards. Students will be notified of changes in the School’s immunization policy and will be held responsible for complying with the most current requirements of the School. Currently, and in accord with UCDH policy, all students are required to receive seasonal flu and Tdap vaccinations.

NOTE: YOU WILL NOT BE ALLOWED IN ANY STUDENT-RUN CLINICS OR HOSPITAL SETTINGS IF YOU ARE NOT COMPLIANT WITH THE CRITERIA ABOVE. IMMUNIZATION REQUIREMENTS CAN CHANGE AT ANY TIME AND STUDENTS ARE EXPECTED TO ADHERE TO CURRENT REQUIREMENTS.

You will be required to provide the following form to your Primary Care Physician in order to confirm that you have received all necessary vaccines: UC Davis School of Medicine Health Requirements Form
UC Davis School of Medicine Health Requirements

All medical students must have the following immunization and infectious disease/immunity screening performed before attendance at UCD SOM. This form must be completed by your health care provider.

STUDENT NAME (Please print): ________________________________

1. Proof of Immunity - Please enter DATES for the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Titer/Dates</th>
<th>Vaccines/Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Measles Titer</td>
<td>____________</td>
<td>#1: ____________ #2: ____________</td>
</tr>
<tr>
<td>(Date)</td>
<td>(Date)</td>
<td>(Date)</td>
</tr>
<tr>
<td>Positive Mumps Titer</td>
<td>____________</td>
<td>#1: ____________ #2: ____________</td>
</tr>
<tr>
<td>(Date)</td>
<td>(Date)</td>
<td>(Date)</td>
</tr>
<tr>
<td>Positive Rubella Titer</td>
<td>____________</td>
<td>#1: ____________ #2: ____________</td>
</tr>
<tr>
<td>(Date)</td>
<td>(Date)</td>
<td>(Date)</td>
</tr>
<tr>
<td>Positive Varicella Titer</td>
<td>____________</td>
<td>#1: ____________ #2: ____________</td>
</tr>
<tr>
<td>(Date)</td>
<td>(Date)</td>
<td>(Date)</td>
</tr>
<tr>
<td>Positive Quantitative Hepatitis B</td>
<td>____________</td>
<td>____________ (see Note)</td>
</tr>
<tr>
<td>(see Note)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B Vaccines</td>
<td>#1: __________ #2: __________ #3: __________</td>
<td>MMR/Rubella Vaccines: #1: ____________ #2: ____________</td>
</tr>
<tr>
<td>(Date)</td>
<td>(Date)</td>
<td>(Date)</td>
</tr>
</tbody>
</table>

Note: The vaccination series ALONE is not sufficient. A Hepatitis B Surface Antibody Quantitative number value ≥12 is required, not a DNA – PCR. ONLY a Quantitative Hepatitis B titer will be accepted.

Negative Hepatitis C Titer Date: ____________

T-dap Vaccination Date: ________________

Tuberculosis: What was the result of your last tuberculosis screening? The tuberculosis screening is annual.

1st PPD Placed Date: ____________ Read Date: ____________mm induration _____ □ positive □ negative
2nd PPD Placed Date: ____________ Read Date: ____________mm induration _____ □ positive □ negative

OR

Quantiferon Date: ____________ Result □ positive □ negative

Chest X-Ray: In case of a positive tuberculosis screening, chest X-ray must be 3 months of start date. It is a confirmation to rule out active Tuberculosis disease.

Date: ____________ Result: ____________ Institution: _____________________________________

Were you treated? ____________ How long were you treated? ____________ Institution: ________________

I verify that the above information is accurate and true. (Please provide facility stamp below)

Name/Title: ________________________________
Signature: ________________________________
License #: ________________________________
State/Country: ______________________________
Phone#: ________________________________
E-mail Address: ______________________________
Date: ________________________________