# 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. Please note: Vaccination records/labs alone are NOT sufficient.

**STUDENT NAME (Please print):** ________________________________

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

<table>
<thead>
<tr>
<th>Disease/Condition</th>
<th>Date of Vaccination</th>
<th>Test/Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles Titer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps Titer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella Titer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella Titer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** The vaccination series ALONE is not sufficient for Hep B. A quantitative Hep B Titer (quantitative number value & date) is sufficient

### T-Dap Vaccination Date:

- #1: __________________________

### Tuberculosis:

- Date: ______________
- Result: ______________
- PPD: mm induration
- positive □ negative □

### Chest X-Ray:

- Date: ______________
- Result: ______________
- Institution: ________________________________

- INH: If you have taken INH, give dates: from ______________ to ______________
- 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: ________________

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For specific instructions please see “Incoming Student Health Requirement Factsheet 2017”: