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:

| Positive Measles Titer: ___________ (Date) OR | MMR/Measles Vaccines: #1: ___________ #2: ___________ (Date) |
| Positive Mumps Titer: ___________ (Date) OR | MMR/Mumps Vaccines: #1: ___________ #2: ___________ (Date) |
| Positive Rubella Titer: ___________ (Date) OR | MMR/Rubella Vaccines: #1: ___________ #2: ___________ (Date) |
| Positive Varicella Titer: ___________ (Date) OR | Varicella (Chicken Pox) Vaccines: #1: ___________ #2: ___________ (Date) |
| Positive Quantitative Hepatitis B: ___________ (see Note) | Surface Antibody Titer (Date) (Value) |
| Hepatitis B Vaccines: #1: ___________ #2: ___________ #3: ___________ (Date) (Date) (Date) |

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.

T-Dap Vaccination Date: #1: ____________________

Tuberculosis: What was the result of your last tuberculosis screening? The tuberculosis screening is annual. Please see “Incoming Student Health Requirements Factsheet 2020” for instructions.

1st PPD Date: ___________ Result: _______ mm induration □ positive □ negative
2nd PPD Date: ___________ Result: _______ 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: ________________________________

For specific instructions please see “Incoming Student Health Requirements Factsheet 2020”: