UC DAVIS HEALTH | SCHOOL OF MEDICINE
Registrar's Office

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Student Health Clearance Form

This form must be completed by your health care provider. In lieu of this form, you may provide lab reports of your immunizations. You will upload your immunizations and/or this form to your myRecordtracker account.

Name: ________________________ / __________________________ / __________ Date of Birth: ______ / ______ / ______
Last First MI MM DD YYYY

REQUIRED IMMUNIZATION DOCUMENTATION FOR INFECTIOUS DISEASES CLEARANCE

TB Screening

Requirement: 1st PPD within the last 365 days and 2nd PPD or QuantiFERON within 90 days prior to start date.
**For positive PPD or QuantiFERON test, a chest x-ray is required within 90 days prior to start date (step C)

A. QuantiFERON (Preferred): Test Date: ______ /______ /______ Results: _________
Date of Annual TB Symptoms Interview: ______ /______ /______ ☐ Neg ☐ Pos**
History of BCG Vaccination: ☐ Yes ☐ No (BCG is a vaccine given to those born outside the US.)

B. Two-step Tuberculin Intermediate Skin Test (PPD):
Test 1 Date: ______ /______ /______ Reading: ______ /______ /______ Results:______MM Induration: ☐ Neg ☐ Pos**
Test 2 Date: ______ /______ /______ Reading: ______ /______ /______ Results:______MM Induration: ☐ Neg ☐ Pos**

C. Chest X-ray: Date: ______ /______ /______ Results: _______________ TB Symptoms: ☐ Neg ☐ Pos
History of Treatment: ☐ Yes ☐ No If yes, Date: ______ /______ /______ How many months?: _______________

MMR or Individual Measles, Mumps and Rubella

Requirement: Two immunization dates (dated at least 28 days apart) OR positive titer

A. MMR Vaccines: 1. ______ /______ /______ 2. ______ /______ /______
OR
B. Individual Measles, Mumps and Rubella Vaccines:
Measles: 1. ______ /______ /______ 2. ______ /______ /______ **OR** Titer Date: ______ /______ /______ ☐ Neg ☐ Pos
Mumps: 1. ______ /______ /______ 2. ______ /______ /______ **OR** Titer Date: ______ /______ /______ ☐ Neg ☐ Pos
Rubella: 1. ______ /______ /______ **OR** Titer Date: ______ /______ /______ ☐ Neg ☐ Pos

Varicella Vaccine (chicken pox)

Requirement: Two vaccination dates (28 days apart) OR positive titer

Varicella Vaccines: 1. ______ /______/______ 2. ______ /______ /______ **OR** Titer Date: ______ /______ /______ ☐ Neg ☐ Pos

Tdap Vaccine (tetanus, diphtheria, pertussis) *must be within last 10 years

Tdap Vaccine: 1. ______ /______ /______

COVID-19 Vaccine

Manufacturer Name: _______________ Lot Number 1: _______________ Date Vaccinated Dose 1. ______ /______ /______
Manufacturer Name: _______________ Lot Number 2: _______________ Date Vaccinated Dose 2. ______ /______ /______
Manufacturer Name: _______________ Lot Number 3: _______________ Date Vaccinated Dose 3. ______ /______ /______

Hepatitis B and C (Hep C is Recommended)

A. Hepatitis B: Surface Antibody Titer Date: ______ /______ /______ Numeric Value*: _______________ mIU/ml ☐ Neg ☐ Pos
*numeric value required, must be quantitative
Hepatitis B Injection Dates: 1. ______ /______/______ 2. ______ /______ /______ 3. ______ /______/______
HEPLISAV-B Injection Dates: 1. ______ /______/______ 2. ______ /______ /______
B. Hepatitis C (Recommended): Surface Antibody Titer Date: ______ /______/______ Results: ___________

All information below (including stamp) is required. Incomplete forms will not be accepted.
I verify that the health requirement information provided is accurate and true.

Primary care physician's name: ____ Date*: __________________

PCP signature: ______________________________________ PCP Business Stamp:

*Dates added after PCP signature will not be accepted. Instead, complete a new form or upload lab results to your MyRecordTracker.