

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 prior to entering (if you begin classes in July or September , the form is due no later than 2 weeks prior to the start of class. Please complete this ASAP. If you do not meet health clearance requirements listed below you will be held from class and/or lab 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](http://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 the past year dated 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) **or** Hepatitis B antibody titer.

\*\* (**Please Note**: If you **do not** have a positive Hepatitis B antibody titer you must provide Hep B series dates.

Hep B #1 **⁯** Hep B # 2 **⁯** Hep B #3 **⁯ or** Hep B Surface Antibody titer **⁯**

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

Varicella #1 **⁯** Varicella # 2 **⁯** **or** positive Varicella titer **⁯**  **or** Date of Disease **⁯**

**5. Tetanus**: A one-time Tdap (Pertussis component included) is required. Also include the date of your last Td. **⁯**

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

Gold serology orT-Spot results.

TST result #1 **⁯** TST result #2  **⁯ or** Quantiferon Gold / Tspot 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 ⁯ Symptom Review**

**Remember you must submit the completed Health Clearance Form with proper documentation and be cleared by Student Health before you can attend classes or receive a paycheck.**



**STUDENT HEALTH CLEARANCE FORM**

**UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL**

**55 Lake Avenue North**

**Worcester, MA 01655**

**Phone (508)334-8464**

**Fax (774)443-2350**

**studenthealth@umassmemorial.org**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M\_\_\_\_\_ F\_\_\_\_\_\_**

**Last First Middle**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street City State Zip**

**TELEPHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ENTRANCE YEAR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SCHOOL: Graduate School of Biomedical Sciences**

The following information **MUST** be completed by the applicant’s healthcare provider, **BEFORE** he/she can attend class.

**PROVIDER COMPLETES**

**Medical History:** Please list all chronic medical conditions: **⁯ Check here if this patient currently has, or has a history of Blood Borne Pathogen Infection (i.e. HIV, Hepatitis B, or Hepatitis C). Please provide details in medical history.**

**Surgical History:**

**Allergies:** (medications, foods, latex, environmental)

**Current Medications:**

**\*\*If you require close follow-up for any medical or mental health issues, please contact us ahead of time to ensure that you receive continuity of care.**

Medical Care – 508-334-8464 Mental Health Care – 508-856-3220

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**Student Last Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB** \_\_\_\_\_\_\_\_\_

**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) **or** positivetiter 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)

Rubella titer: \_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY) **Lab reports MUST be attached**.

Mumps titer: \_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)

**3. TETANUS DIPTHERIA (Td/Tdap):** A one- time Tdap **2006 or after** is **required**. Include last Td date also.

Tdap \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY) Td \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/ DD/YY)

**4. HEPATITIS B:** Provide Hepatitis B immunization dates (3 doses) **or** a positive Hepatitis B surface antibody titer. A copy of the titer report **MUST** be attached**.**

Hep B #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY) Hep B #4 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)

Hep B #2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY) Hep B #5 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)

Hep B #3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY) Hep B #6 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)

HBSab Titer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY) Result: Positive ⁭ Negative ⁭

**5. VARICELLA (Chickenpox):** Varicella Immunization (2 doses) **or** a positive Varicella Titer **(lab report MUST be attached).**

Varicella #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)

Varicella #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)

Varicella Titer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY) Do you have a history of Varicella? Yes ⁭ No ⁭ If Yes, Date: \_\_\_\_\_\_\_\_\_\_\_\_

**6. 2- STEP TUBERCULIN SKIN TEST (TST)**: 2 step TST **or** Quanterferon Gold Test or equivalent serology 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 \_\_\_\_\_\_\_\_ (**Attach 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**.**

SYMPTOM REVIEW\ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (See back of attached TST form)

EXAMINER SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MD/ NP/ PA

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