

UMASS STUDENT HEALTH CLEARANCE FORM

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Email Contact \_\_\_\_\_ Phone Contact \_\_\_\_\_

GSBS \_\_\_\_\_ Gender \_\_\_\_\_

This form must be completed and signed by your healthcare provider with supporting immunization documentation and lab reports. Please submit this form ASAP. The stringent medical requirements for UMMS health clearance can take up to 2 months to complete. If not completed by the start of school, you may be restricted from classes/school activities. Please upload all your information/questions to the Peoplesoft portal only. Provide dates in the spaces below. Documents will be stored in EPIC, UMMHC Electronic Medical Record.

MMR # 1 _____ (1 <sup>st</sup> dose must be at 1 year of age or older)	MMR #2 _____	<b>OR</b> Measles IGG _____ pos/ neg Mumps IGG _____ pos/ neg Rubella IGG _____ pos/ neg
Tdap _____ One dose of Tdap ≥ age 11. If last Tdap is more than 8 years ago, a Td or Tdap update is required.		
Tdap _____ Td _____		
Hepatitis B #1 _____ Hepatitis B #2 _____ Hepatitis B #2 _____ <b>OR</b> Positive Hep B Surface Antibody Titer _____ pos/neg  <b>If the Hep B Surface Antibody titer is negative or equivocal, booster is recommended</b>  Hepatitis B Booster _____		
Varicella #1 _____ Varicella #2 _____ <b>OR</b> Positive Varicella IGG titer _____ (1 <sup>st</sup> dose must be at 1 year of age or older)		
COVID VACCINE #1 _____ (MANUFACTURER) _____	COVID VACCINE #2 _____ (MANUFACTURER) _____	BOOSTER _____ (MANUFACTURER) _____
<b>TB REQUIREMENT</b> IGRA (Quantiferon Gold or T-SPOT) (IGRA is preferred) <b>OR</b> 2 step TST completed within 3 months prior to school start date. The minimum interval between the 1 <sup>st</sup> and 2 <sup>nd</sup> TST is one week between each test date.  (Circle One) Quantiferon Gold/ Tspot _____ pos/ neg  TST #1 _____ result _____ mm and TST #2 _____ result _____ mm  If you have a history of a positive TST or IGRA provide date. Copy of written Chest X – Ray Report and complete Symptom Review are required.  Date of Positive Result _____ Chest X-Ray Report Date _____		
Physical completed within 1 year prior to school start _____		
Signature of Provider _____ Printed Name: _____ Date: _____		