UC Law SF New Student
Health Form

Student Name________________________________Date of Birth (MM/DD/YY)_______________ Student ID #_______________________________

All new UC Law SF students are REQUIRED to obtain the following vaccines, complete this form, and submit a copy of immunization or medical records, which provide proof of immunization. Failure to provide this information by the deadline will result in an academic hold on your record, preventing you from registering for spring semester classes. A healthcare provider must complete and sign this form.

A: Required Vaccination and Screening

Please state the dates (MM/DD/YY) of the required vaccine or titers (laboratory evidence of immunity to disease) and tuberculosis screening (as appropriate) below.

Vaccination or Screening	Required Dose	First Dose	Second Dose	Titer Levels (if unable to provide vaccine records)
Measles, Mumps & Rubella (MMR) Vaccine	Two doses with first dose on or after 1st birthday; OR positive titer			
Varicella (chickenpox) Vaccine	Two doses, with first dose on or after 1st birthday, OR positive titer			
Tetanus, Diphtheria, & Pertussis (TDAP) Vaccine	One dose after age 7; tetanus booster every 10 years after initial TDAP.			
Meningococcal Conjugate (Serogroups A, C, Y & W-135) Vaccine	One dose on or after age 16 for all students who are ages 21 or younger	N/ A if over age 21		

B: Tuberculosis Risk Assessment

1. Have you traveled or lived for more than a month in a country with a high rate of Tuberculosis (TB)?
   - Yes
   - No
2. Were you born in a country with high rates of TB?
   - Yes
   - No
3. Have you been a resident or employee of high-risk congregate setting, e.g., correctional facility, long-term care facility, or homeless shelter?
   - Yes
   - No
4. Have you been a member of any of the following groups that may have increased risk of latent M. Tuberculosis infection or active TB disease, e.g., medically underserved, low-come, or drug & alcohol abusers?
   - Yes
   - No
5. Have you had close contact with anyone who was sick with TB?
   - Yes
   - No
6. Have you been a volunteer or healthcare worker who served clients who had increased risk of active TB disease?
   - Yes
   - No

If you answered "NO" to all questions in Section B, no further action or testing is required.

If you answered "Yes" to one or more questions in Section B, you are required to receive TB testing & a healthcare provider must complete the attached Tuberculosis Screening Form.

C: Certification

I certify that to the best of my knowledge this information is complete and accurate. I have read and understand the immunization requirements for incoming students. I agree to submit a copy of my immunization record or medical records providing proof of immunization to Carboh Health via my Carbon Health portal.

____ _________________________

Student Signature Date

____

Student UC Hastings Phone Number and Email Address

____ _________________________

Healthcare Provider Signature Date

____ _________________________

Healthcare Provider Name and Title Healthcare Provider License Number

____

Healthcare Provider Phone Number and Email Address

Tuberculosis Health Assessment Form

Student Name________________________________Date of Birth (MM/DD/YY)_______________ Student ID #______________________________

This student has been identified through an initial screening and is **REQUIRED** to complete one of the approved tuberculosis tests below before enrolling in classes. This form must be completed and signed by a licensed healthcare provider, with test results attached.

<table>
<tr><td colspan="2">One skin test required for NON-Healthcare Professional Students:
TUBERCULIN SKIN TEST (TST) OR TB BLOOD TEST (Recommended if history of BCG/TB Vaccine)</td></tr>
<tr><td>Date placed: ______________ Date read: ____________
(must be read between 48-72hrs after it was placed)
Result: _ mm induration.
Interpretation:
Negative Positive
(IF POSITIVE, PROCEED TO SYMPTOMS & BLOOD TEST OR CHEST X-RAY)

Two skin tests required for Healthcare Professional Students:
Date placed:______________Date read:
(must be read between 48-72hrs after it was placed)
Result: mm induration.
Interpretation: Negative Positive
(IF POSITIVE, PROCEED TO SYMPTOMS & BLOOD TEST OR CHEST X-RAY)</td><td>QUANTIFERON or T-SPOT
(Interferon Gamma Release Assay – IGRA)
If not available, may do a Tuberculin Skin Test (TST) or Chest X-ray.
Date QTF/T-SPOT Test: ________________________
Result:
Negative Positive
(IF POSITIVE, PROCEED TO SYMPTOMS & CHEST X-RAY)

Indeterminate
(IF INDETERMINATE, REPEAT TEST OR PROCEED TO CHEST X- RAY)</td></tr>
<tr><td colspan="2">SYMPTOMS:
Does your patient have any of the following symptoms? (please check any that apply)
Cough for greater than 4wks Coughing up blood Unexplained Chest pain Persistent fever/chills/night sweats Persistent, unexplained fatigue Unexplained weight loss</td></tr>
<tr><td colspan="2">CHEST X-RAY (REQUIRED if TST or Quantiferon/IGRA +/or Symptoms are positive OR previous treatment for TB)</td></tr>
<tr><td colspan="2">Date of Chest x-ray:_________________________ Result:
Normal Abnormal
MUST ATTACH <u>WRITTEN</u> RADIOLOGY CHEST XRAY REPORT IN ENGLISH (DO NOT SEND FILMS/CD of actual X-ray)</td></tr>
</table>

____
Healthcare Provider Signature

____
Date

____
Healthcare Provider Name and Title

____
Healthcare Provider License Number

____
Healthcare Provider Phone Number and Email Address