For your protection and that of patients with whom you will come in contact during training, all students must meet established health requirements. **REFER TO PROGRAM REQUIREMENTS FOR DUE DATE OF IMMUNIZATION DOCUMENTATION!**

Please print the Immunization Checklist form, ensure all required and applicable documentation is attached, and send the documents to IUPUI Campus Health via healthsv@iupui.edu include Last Name, First Name, Program, and Graduation year as the Subject

1. **Health Evaluation Form:** To be completed and signed by a physician or provider (M.D., D.O., N.P., P.A.) upon completion of physical examination and any applicable laboratory testing.

2. **Immunization Checklist Form:**

   **Copies of clinical records MUST be attached for each vaccine or lab test to be considered VALID.**

   - **Hepatitis B** – The vaccine is administered in a series of 3 injections at 0, 1, and 6 months. Students admitted at least 6 months prior to the beginning of classes must provide documentation of completion of the series OR proof of an immune Hepatitis B antibody titer. Students admitted later must at least provide documentation of starting the series prior to attending class. All students must show evidence of having begun the series at the time this form is due.

   - **Measles, Mumps, Rubella (MMR)** – Proof of 2 vaccinations at least 28 days apart OR proof of an immune antibody titer for EACH disease is required. *If you have received individual vaccinations for Measles, Mumps, or Rubella, proof of 2 vaccinations for each individual disease is required.*

   - **Meningitis**– One Meningococcal ACWY vaccine is required.

   - **Tetanus/Diphtheria and Acellular Pertussis (Tdap)** – One vaccine (first available in 2005) is required.

   - **Tetanus Booster** (Td) – One booster is required every 10 years.

   - **Varicella** (Chicken Pox) – Proof of 2 vaccinations at least 28 days apart OR an immune Varicella antibody titer is required. Having the disease as a child is not proof of immunity unless written documentation from treating physician is provided.

   - **Tuberculosis** – Prior to beginning classes, new students must have two completed Tuberculin Skin Tests (TST), if there is no documented proof of a positive TST in the past. The placement of the TSTs must be ≥ 10 days apart. Step 1 must be within 18 months of matriculation and step 2 must be after May 1, 2018. One interferon gamma release assay (IGRA) completed after May 1, 2018 may be substituted for the 2 TSTs. Also, if there is a known history of BCG vaccination, an IGRA blood test is preferred over TST placements.

   The following **must** be included on the TST documentation in order to be considered valid:
   1. DATE and TIME of Placement
   2. DATE and TIME of Reading  *(must be within 48-72 hours of placement)*
   3. Results recorded in “mm”
   4. Placement/Read/Documentation signed by certified medical personnel

   **EXAMPLE OF VALID DOCUMENTATION:**

<table>
<thead>
<tr>
<th>Date Placed</th>
<th>Time Placed</th>
<th>PPD Lot #</th>
<th>Exp Date</th>
<th>Location</th>
<th>Placed By:</th>
<th>Date Read</th>
<th>Time Read</th>
<th>Results (mm)</th>
<th>Read By:</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/02/18</td>
<td>1601</td>
<td>123456</td>
<td>12/2018</td>
<td>LFA</td>
<td>RAF, RN</td>
<td>01/05/18</td>
<td>1246</td>
<td>0mm</td>
<td>TPW, LPN</td>
</tr>
</tbody>
</table>

   IF history of a positive TST or IGRA: Documentation and evidence of a chest x-ray and medical treatment must be provided. A TB Symptom Questionnaire located on the IUPUI Campus Health website ([http://studentaffairs.iupui.edu/health-wellness/student-health/forms/index.shtml](http://studentaffairs.iupui.edu/health-wellness/student-health/forms/index.shtml)) must also be completed and submitted with your documentation.

   **FYI** – All students will be required to participate in annual academic year **TB Surveillance and Flu vaccination while attending IU.**

   You will be contacted via your IU email once your documentation is received and reviewed.
IUPUI Campus Health and the School require you to provide documentation of the following vaccinations. Failure to submit the appropriate documentation may delay or prevent your ability to start your program. We highly recommend you submit your documentation as early as possible. We are not responsible if you submit documentation at the last minute that does not meet requirements.

**Copies of clinical records **MUST** be attached for each vaccine dose or lab test **

**Hepatitis B:** THREE doses are required OR a positive antibody titer (HBsAb)

Vaccinations: #1 ☐ #2 ☐ #3 ☐ OR Evidence of Immunity: Hepatitis B Titer ☐

**MMR** (Measles, Mumps, Rubella): TWO doses are required at least 28 days apart OR a positive antibody titer (IgG) for each

Vaccinations: #1 ☐ #2 ☐ OR Evidence of Immunity: Measles Titer ☐ Mumps Titer ☐ Rubella Titer ☐

**Meningitis** (Meningococcal ACWY): ONE dose is required.

Vaccination: #1 ☐

**Tdap** (Tetanus/Diphtheria and Acellular Pertussis): ONE dose is required from 2005-forward.

Vaccination: #1 ☐

**Td Booster** (Tetanus/Diphtheria): ONE dose is required every 10 years.

Vaccination: #1 ☐

**Varicella** (Chicken Pox): TWO doses are required at least 28 days apart OR a positive antibody titer (IgG)

Having the disease as a child is not proof of immunity unless written documentation from treating physician is provided.

Vaccinations: #1 ☐ #2 ☐ OR Varicella Titer ☐ OR Documented History of Disease ☐

- New students must have two completed Tuberculin skin tests (TST) if there is no documented proof of a positive TST in the past. The placement of the TSTs must be ≥ 10 days apart. **DATE/TIME of TST placement, DATE/TIME of TST read within 48-72 hours, and results recorded in "mm" MUST be recorded on the attached documentation or it is not valid!** One IGRA blood test (T-Spot or Quantiferon Gold) completed after May 1, 2018 may be substituted for the TSTs. If there is a known history of BCG vaccination, an IGRA blood test is preferred.

**TB Screening:** TWO TSTs are required (IF no history of positive TST) OR one IGRA blood test may be substituted

**Step 1:** (not >18 months before matriculation) ☐ Step 2: (from May 1, 2018 forward) ☐ OR an IGRA (from May 1, 2018 forward) ☐

IF history of a positive TST or IGRA: Documentation and evidence of any chest x-ray and medical treatment must be provided. A TB Symptom Questionnaire located on the IUPUI Campus Health website (http://studentaffairs.iupui.edu/health-wellness/student-health/forms/index.shtml) must also be completed and submitted with your documentation.

**Positive History for TB Screening:** If documented history of positive TST or IGRA, documentation/evidence of the positive result, Chest X-Ray, and completed TB Symptom Questionnaire are required

**ANY Positive TST skin test or IGRA:** ☐

Follow Up Treatment: Chest XR ☐ TB Treatment? ☐ Yes ☐ No ☐ TB Symptom Questionnaire ☐
Indiana University Health Care Student
Health Evaluation

NAME: __________________________ GENDER: M / F / T DATE OF BIRTH: __ / __ / ___

(Please print legibly)

Family History:
Father: __________________________ Mother: __________________________ Siblings: __________________________
□ Living (Age __) □ Living (Age __)

Occupation: __________________________ Occupation: __________________________
□ Deceased □ Deceased
Age at Death: _______ Age at Death: _______
Cause: __________________________ Cause: __________________________

□ Deceased
Age at Death: _______
Cause: __________________________

Allergies: __________________________

Surgical History: __________________________

Medication: __________________________

Have you or any of your relatives had any of the following? (Please include parents, grandparents, aunts, uncles, and siblings)

Allergies - food, environment, medications □ □ Musculoskeletal disease - arthritis, etc. □ □
Dermatological - eczema, psoriasis, etc. □ □ Neurological - seizures, migraines, etc. □ □
Gastrointestinal disease - GERD, UC, IBS, etc. □ □ Obesity □ □
GYN/GU - breast or prostate, etc. □ □ Psychiatric - anxiety, depression, bipolar, etc. □ □
Hematological - hemophilia, DVT, etc. □ □ Pulmonary disease - asthma, COPD, TB, etc. □ □
Heart disease or high blood pressure □ □ Visual/Hearing Problem □ □
Immunological - lupus, scleroderma, etc. □ □ Other □ □
Kidney Disease □ □

Lifestyle:
Diet: __________________________ Exercise: __________________________
□ Regular □ Low Fat □ None □ Light □ Tobacco □ No □ Yes □ Alcohol □ No □ Yes
□ Vegetarian □ Gluten-Free □ Moderate □ Heavy □ Seat Belts □ No □ Yes □ Caffeine □ No □ Yes

Comments: __________________________ Other: __________________________

General Overall Appearance:

PHYSICAL EXAM

Height: _______ Weight: _______ BMI: _______ Blood Pressure: _______ Pulse: _______ Respiratory Rate: _______

Skin: _______ Head: _______ Ears: _______ Nose: _______ Throat: _______

Lymphadenopathy: _______ Neck: _______ Heart: _______

Chest: _______ Spine: _______ Abdomen: _______

Extremities: _______ Neurological: _______

Comments: __________________________

Laboratory Exam (if appropriate):

CBC: Red Blood Count (RBC) _______ Hemoglobin (Hgb) _______ Hematocrit (HCT) _______ White Blood Count (WBC) _______

Urinalysis: pH _______ Specific Gravity _______ Protein _______ Glucose _______ Bilirubin _______

PROVIDER EVALUATION

Student is determined to be physically and mentally able to attend medical school: □ Yes □ No

Provider Recommendations: No: _______ Yes - explain: _______

Limitations: No: _______ Yes - explain: _______

Date: _______ / _______ / _______ Signed: __________________________ Printed: __________________________ (Provider’s name printed)

OFFICE STAMP

Rev 02/10/2017