 **UMASS STUDENT HEALTH CLEARANCE FORM**

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

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

Circle one: Med GSN GSBS (MSCI, CPHR, CPPT, MD/Phd, MSPP, MSPT)

**This form must be completed and signed by the student’s healthcare provider. Dates alone are not accepted. Supporting Immunization Documentation and Lab Reports are REQUIRED. Please refer to the Student Health website for further explanation and details of health requirements. Please scan/email your form back to Student Health once completed.** Studenthealth@umassmemorial.org

**\*Please complete no later than 2 weeks prior to school start or you may be restricted from classes/activities \***

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| **MMR # 1 \_\_\_\_\_\_\_\_\_\_\_\_ MMR #2 \_\_\_\_\_\_\_\_\_\_\_ AND Measles IGG\_\_\_\_\_\_\_\_\_\_\_ pos/neg**  **Mumps IGG \_\_\_\_\_\_\_\_\_\_\_ pos/neg** **MMR Booster if indicated­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_ Rubella IGG \_\_\_\_\_\_\_\_\_\_\_ pos/neg** |
| **Tdap \_\_\_\_\_\_\_\_\_ Td \_\_\_\_\_\_\_\_ (One dose of Tdap is required ≥ age 11. If last Tdap is more than 10 years old, a Td update is required.**  |
| **Hepatitis B #1 \_\_\_\_\_\_\_\_\_ Hepatitis B #2 \_\_\_\_\_\_\_\_\_\_\_ Hepatitis B #3 \_\_\_\_\_\_\_\_\_\_\_\_\_****Hepatitis B surface antibody titer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ pos/neg** **If the Hepatitis B surface antibody titer is negative you must complete the following:****Hepatitis B surface antigen \_\_\_\_\_\_\_\_\_\_\_\_\_****Hepatitis B core antibody \_\_\_\_\_\_\_\_\_\_\_\_\_\_****Hepatitis B booster #4 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Repeat Hepatitis B surface antibody titer 6-8 weeks after booster #4 \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ pos/neg****If titer remains negative Hep B #5\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hep B #6\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ are required**  |
| **Varicella #1 \_\_\_\_\_\_\_\_\_\_\_\_ Varicella #2 \_\_\_\_\_\_\_\_\_\_\_ OR Positive Varicella IGG titer \_\_\_\_\_\_\_\_\_\_\_\_** |
| **TB REQUIREMENT: IGRA OR 2 step TST (IGRA is preferred) Completed within 3 months of school start date.****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 documentation and copy of Chest X – Ray Report.** **Date of Positive Result \_\_\_\_\_\_\_\_\_\_\_ Chest X-Ray Report Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Treatment Yes or No****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Physical completed within 1 year prior to school start \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ CLINIC/OFFICE STAMP****Signature of Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_****Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
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