



UMASS STUDENT HEALTH CLEARANCE FORM

Last Name _____ First Name _____ Date of Birth _____

Email Contact _____ Phone Contact _____

Circle one: MED GSN CPHR MSPT CPPT MSC I HSPP MMPP MD/PhD 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 st dose must be at 1 year of age or older)	MMR #2 _____ MMR Booster indicated if titer is low. _____	AND Measles IGG _____ pos/ neg Mumps IGG _____ pos/ neg Rubella IGG _____ pos/ neg
Tdap _____ One dose of Tdap ≥ age 11. If last Tdap is <u>more than 8 years ago</u> , a Td or Tdap update is required. (Tdap preferred) Tdap _____ Td _____		
Hepatitis B #1 _____ Hepatitis B surface antibody titer (Quantitative) _____ (date) _____	Hepatitis B #2 _____ Hep B Booster #4 _____	Hepatitis B #3 _____ AND (value) pos/neg Repeat Hepatitis B surface antibody titer 6-8 weeks after booster #4 _____ pos/ neg If titer remains negative Hepatitis B booster #5 _____ Hepatitis B booster #6 _____ are required
If the Hep B Surface Antibody titer is negative or equivocal, please complete the titers below <u>BEFORE</u> receiving the booster		
Hepatitis B surface antigen _____ pos/neg Hepatitis B core antibody _____ pos/neg		
Varicella #1 _____ Varicella #2 _____ OR Positive Varicella IGG titer _____ (1 st dose must be at 1 year of age or older)		
COVID VACCINE #1 _____ (MANUFACTURER) _____ COVID VACCINE #2 _____ (MANUFACTURER) _____ BOOSTER _____ (MANUFACTURER) _____		
TB REQUIREMENT IGRA (Quantiferon Gold or T-SPOT) (IGRA is preferred) OR 2 step TST completed within 3 months prior to school start date. The minimum interval between the 1 st and 2 nd 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 _____		
Date of Physical - Must be completed within 1 year prior to school start: _____		
Signature of Provider: _____ Printed Name: _____ Date: _____		