University of Massachusetts
UMASS Medical School

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 attached. Please complete 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.

Important: All information must be uploaded to the PeopleSoft Portal ONLY.

MMR # 1_____ MMR #2_____ AND Measles IGG_____ pos/ neg
(1st dose must be at 1 year of age or older) Mumps IGG _____ pos/ neg
Rubella IGG _____ pos/ neg

MMR Booster if indicated_____

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 #3 _____ AND
Hepatitis B surface antibody titer (Quantitative) _____ pos/ neg

If the Hep B Surface Antibody titer is negative or equivocal, please complete the titers below BEFORE receiving the booster

Hepatitis B surface antigen _____
Hepatitis B core antibody _____

Hep B Booster #4_____

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

Varicella #1 _____ Varicella #2 _____ OR Positive Varicella IGG titer_____
(1st dose must be at 1 year of age or older)

COVID VACCINE #1_____ COVID VACCINE #2_____ MANUFACTURER _____

TB REQUIREMENT IGRA OR 2 step TST (IGRA is preferred) completed within 3 months prior to school start date. The minimum interval between the 1st and 2nd step 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 Chest X – Ray Report and complete Symptom Review

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: _____