UC San Diego
STUDENT HEALTH AND WELL-BEING
Student Health Services

INCOMING HEALTH REQUIREMENTS
SCHOOL OF MEDICINE &
SKAGGS SCHOOL OF PHARMACY

Student ID:	Date of Birth: (MM/DD/YYYY)	Name: First Last

STUDENT AUTHORIZATION TO RELEASE INFORMATION (this portion must be signed by the incoming student)
I authorize UCSD Student Health Services to share information on this form to UCSD School of Medicine/Skaggs School of Pharmacy Student Affairs for the purpose of clinical placement requirements.

STUDENT SIGNATURE: _____ **DATE:**_____**CELL PHONE NUMBER**:_____

Required Immunizations	Required Data PLEASE UPLOAD ALL LABORATORY REPORTS
Tdap (tetanus, diphtheria, pertussis) Td boosters are required every 10 years	**One adult Tdap (after the age of 10). If last Tdap is more than 10 years old, provide last date of Td and Tdap (required)** Tdap Dose date: _____/____/_____ Td Dose date: _____/____/_____
Measles (Rubeola) **Mumps** **Rubella** 2 doses of MMR vaccine **OR** 2 doses of Measles 2 doses of Mumps and 1 dose of Rubella **OR** Serologic proof (blood titer) of immunity for Measles, Mumps and/or Rubella If vaccination is required, first dose must be completed prior to the first day of classes.	**MMR Immunizations** Dose 1 date: _____/_____/_____ Dose #1 must be on or after first birthday Dose 2 date: _____/_____/_____ Dose 3 date: _____/_____/_____ (if titer negative) Dose 4 date: _____/_____/_____ (if titer negative) **: OR** **Measles: 2 doses of vaccine OR positive serology** **Positive Measles IgG Antibody titer** Titer date: _____/_____/_____ **(a positive titer meets requirement)** **Measles Vaccine Doses x 2** Dose 1 date: _____/_____/_____ Dose 2 date: _____/_____/_____ **Positive Mumps IgG Antibody titer** Titer date _____/_____/_____ **(a positive titer meets requirement)** **Mumps Vaccine Doses x 2** Dose 1 date: _____/_____/_____ Dose 2 date: _____/_____/_____ **Positive Rubella IgG Antibody titer** Titer date _____/_____/_____ **(a positive titer meets requirement)** **Rubella Vaccine Doses x 2** Dose 1 date: _____/_____/_____ Dose 2 date: _____/_____/_____ If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer 4-6 weeks post vaccination. If titer is still negative, receive a second dose of vaccine and repeat titer 4-6 weeks later. Vaccine doses must be at least 28 days apart.

Varicella (Chicken Pox) 2 doses of vaccine **OR** Positive serology If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer 4-6 weeks post vaccination. If titer is still negative, receive second dose of vaccine and repeat titer 4-6 weeks later. Vaccine doses must be at least 28 days apart.	**Positive Varicella IgG Antibody titer (required)** Titer date _____/_____/_____ **(only a positive titer meets requirement)** **OR** **Varicella Immunizations** Dose 1 date: _____/_____/_____ Dose #1 must be on or after the first birthday Dose 2 date: _____/_____/_____ Please check titer first before receiving vaccine
Hepatitis B Two (2) or three (3) doses of vaccine followed by a **Quantitative** Hep B Surface Antibody (titer) preferably drawn 4-8 weeks after 3rd dose. If negative, complete a second Hep B series followed by a repeat titer. If Hep B Surface Antibody is negative after secondary series, additional testing including Hep B Surface Antigen should be performed. https://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf	**Hepatitis B Immunizations (required)** Dose 1 date: _____/_____/_____ Dose 2 date: _____/_____/_____ Heplisav B is a 2 dose series Dose 3 date: _____/_____/_____ **Positive Hepatitis B Surface Antibody titer (required) QUANTITATIVE** Titer date: _____/_____/_____**(only a positive titer meets requirement)** **If Hepatitis B Surface Antibody is negative after a full a full primary series, repeat Hepatitis B series** Dose 4 date: _____/_____/_____ Dose 5 date: _____/_____/_____ Dose 6 date: _____/_____/_____ **Positive Hepatitis B Surface Antibody titer (required) QUANTITATIVE** Titer date: _____/_____/_____ **(only a positive titer meets requirement)**
Required if a history of Hep B infection **OR** **Negative Hep B surface antibody** after 2 primary series of Hep B vaccine **OR** **Chronic active Hep B**	**Hepatitis B Core Antibody titer** Titer date: _____/_____/_____ **Hepatitis B Surface Antigen titer** Titer date: _____/_____/_____
Meningococcal Conjugate (MCV4) 1 dose on or after age 16 for all students up to the age of **22 years or younger**	Dose date: _____/_____/_____
COVID-19 Vaccine FDA or WHO-Approved vaccines **OR** ☐ I affirmatively **decline** the COVID vaccine at this time **Initials:**_____ **Date:**_____	**Please circle:** Pfizer, Moderna, Janssen, Covisheild, Sinopharm, Sinovac-CoronaVac, Covaxin, AsraZeneca, Novavax, CanSino **Primary Series (1 or 2) dose vaccine** Dose 1 date: _____ Dose 2 date: _____ **Please upload proof of vaccine** **Booster/Additional Dose(s)** Dose 1 date: _____ Dose 2 date: _____ Dose 3 date: _____ Dose 4 date: _____ **Please go to Menu > COVID-19 to self-enter dates and upload proof of Covid vaccines only**

I ATTEST THAT ALL DATES AND IMMUNIZATIONS LISTED ON THIS FORM ARE CORRECT AND ACCURATE

Providers Signature: _____ Practice Stamp:

Provider's Name: _____
(Physician/PA/NP/RN)

Date: _____