UC RIVERSIDE | School of Medicine

Annual Student Immunization Requirements

Health Screening Requirements: Immunization/Infectious Disease Status:
NOTE: Required of ALL incoming and continuing students on an annual basis.

Name: _____ Student ID#: _____

Birth date: _____ E-Mail: _____

Tuberculosis Screening *– IGRA (Interferon gamma releasing assay) blood test is required.*
NOTE: PPD skin test is not accepted as proof of absence of tuberculosis.

IGRA Blood Test: Specify the date and result of serologic blood test for Tuberculosis. *If the result is **positive**, a chest x-ray is required.*

Test Date: _____ Result: _____positive _____negative

ONLY REQUIRED IF IGRA RESULT IS POSITIVE:

1. Have you received BCG (TB immunization) in the past? (If yes, date___/___/___)	□ No □ Yes
2. Have you had MMR or Varicella vaccine within the last 60 days? (If yes, date (_____/_____/_____)	□ No □ Yes
3. Do you have a persistent cough (lasting 3 weeks or more)?	□ No □ Yes
4. Do you cough up blood?	□ No □ Yes
5. Do you have persistent, unexplained fevers or night sweats?	□ No □ Yes
6. Do you have a rash? If "Yes", for how long? _____	□ No □ Yes
7. Do you have unintentional weight loss fatigue, or loss of appetite?	□ No □ Yes
8. Do you have any reason to believe that your immune system may have been altered or damaged due to any of the following conditions or medications, which could increase you risk for tuberculosis (i.e. cancer; sarcoidosis; HIV/ AIDS; chemotherapy; chronic steroid therapy or medications to prevent transplant rejection)? **Note: HIV infection and other medical conditions may cause a TB (PPD) skin test to be negative even when TB infection is present.**	□ No □ Yes

Chest X-ray (for Tuberculosis screening) If a chest x-ray was performed as a follow-up to a positive IGRA result, record the result here:

Date of Administration: _____ Result: _____positive _____negative

Influenza *– One (1) dose required annually each fall.*

The following documents are acceptable and must contain the individual's name, the location of the vaccination provider, the name of the vaccine and the date administered. Failure to provide at least one (1) of the below requirements will result in disciplinary action:

1. A letterhead note or script with your doctor's signature
2. An updated yellow vaccination card or vaccination record from your doctor's office
3. A receipt or signed document as proof of flu vaccine administration from a pharmacist or outside vendor

Infectious disease status reviewed and updated (by signing below, clinician certifies this to be true).

Signature of Clinician: _____ Date: _____

Name and Title: _____ Phone: _____

Address: _____