Indiana University Health Professions Programs
Health Requirements for Matriculation  2017

For the protection of students and the patients with whom they will come in contact during training, all entering students must meet established health requirements. **FORMS AND IMMUNIZATION DOCUMENTATION DUE PRIOR TO PROGRAM START.**

Please print the Health Evaluation and Immunization Checklist forms, ensure all required and applicable documentation is attached, and scan the documents to IUPUI Campus Health:  healthsv@iupui.edu

*PLEASE NOTE - When corresponding via email, include Last Name, First Name, Program, and Graduation Class in the Subject Line*

1. **Health Evaluation Form:** To be completed and signed by a physician or provider (M.D., D.O., N.P., P.A.) upon completion of physical examination and any applicable laboratory testing.

2. **Immunization Checklist Form:**

   Copies of clinical records MUST be attached for each vaccine or lab test to be considered VALID.

   ✓ **Hepatitis B** – The vaccine is administered in a series of 3 injections at 0, 1, and 6 months. Students admitted at least 6 months prior to the beginning of classes must provide documentation of completion of the series OR proof of an immune Hepatitis B antibody titer. Students admitted later must at least provide documentation of starting the series prior to attending class. All students must show evidence of having begun the series at the time this form is due.

   ✓ **Measles, Mumps, Rubella (MMR)** – Proof of 2 vaccinations at least 28 days apart OR proof of an immune antibody titer for EACH disease is required. *If you have received individual vaccinations for Measles, Mumps, or Rubella, proof of 2 vaccinations for each individual disease is required.*

   ✓ **Tetanus/Diptheria and Acellular Pertussis (Tdap)** – One Tdap (first available in 2005) is required. Td boosters every 10 years thereafter.

   ✓ **Varicella (Chicken Pox)** – Proof of 2 vaccinations at least 28 days apart OR proof of an immune Varicella antibody titer is required. Stating history the disease as a child is NOT proof of immunity.

   ✓ **Tuberculosis** – Prior to beginning classes, new students must have two completed Tuberculin Skin Tests (TST), formerly referred to as a PPD, if there is no documented proof of a positive TST in the past. The placement of the TSTs must be ≥ 7 days apart. Step 1 must be within 18 months of matriculation and step 2 must be after May 1, 2017. **One interferon gamma release assay (IGRA) completed after May 1, 2017 may be substituted for the TSTs.** Also, if there is a known history of BCG vaccination, an IGRA blood test is preferred over TST placements.

   The following **must** be included on the TST documentation in order to be considered valid:

   1. **DATE and TIME** of Placement
   2. **DATE and TIME** of Reading (must be within 48-72 hours of placement)
   3. **Results recorded in “mm”**
   4. Placement/Read/Documentation signed by certified medical personnel

   **EXAMPLE OF VALID DOCUMENTATION:**

<table>
<thead>
<tr>
<th>Date Placed</th>
<th>Time Placed</th>
<th>PPD Lot #</th>
<th>Exp Date</th>
<th>Location</th>
<th>Placed By</th>
<th>Date Read</th>
<th>Time Read</th>
<th>Results (mm)</th>
<th>Read By</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/16/13</td>
<td>1252</td>
<td>123456</td>
<td>12/2015</td>
<td>RFA</td>
<td>MER, RN</td>
<td>02/19/13</td>
<td>1327</td>
<td>0mm</td>
<td>TPW, LPN</td>
</tr>
<tr>
<td>07/01/13</td>
<td>1501</td>
<td>123456</td>
<td>12/2015</td>
<td>LFA</td>
<td>RAF, RN</td>
<td>07/04/13</td>
<td>1246</td>
<td>0mm</td>
<td>TPW, LPN</td>
</tr>
</tbody>
</table>

   If there is history of a positive TST or IGRA in the past, documentation of the positive result and evidence of any chest x-ray and medical treatment received must be provided. Also, for a newly positive TST or IGRA, evidence of a chest x-ray is required along with documentation of any medical treatment prescribed. A TB Symptom Questionnaire located on the IUPUI Campus Health website ([http://health.iupui.edu/employees/forms.html](http://health.iupui.edu/employees/forms.html)) must also be completed and submitted with your documentation.

FYI – All students will be required to participate in annual academic year TB Surveillance, Flu vaccination, and Health Evaluation while attending IU Health Professions Programs.

You will be contacted via email once your documentation is received and reviewed!
**Copies of clinical records MUST be attached for each vaccine dose or lab test**

### Hepatitis B: THREE doses are required OR a positive antibody titer (HBsAb)

<table>
<thead>
<tr>
<th>Vaccinations</th>
<th>Evidence of Immunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>#2</td>
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</tbody>
</table>

### MMR (Measles, Mumps, Rubella): TWO doses are required at least 28 days apart OR a positive antibody titer (IgG) for each

<table>
<thead>
<tr>
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<th>Evidence of Immunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>#2</td>
</tr>
</tbody>
</table>

### Tdap (Tetanus/Diptheria and Acellular Pertussis): ONE dose is required. Td boosters every 10 years thereafter.

<table>
<thead>
<tr>
<th>Vaccination</th>
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</thead>
<tbody>
<tr>
<td>#1</td>
<td></td>
</tr>
</tbody>
</table>

### Varicella (Chicken Pox): TWO doses are required at least 28 days apart OR a positive antibody titer (IgG)

**Note:** Having the disease as a child is not proof of immunity**

<table>
<thead>
<tr>
<th>Vaccinations</th>
<th>Evidence of Immunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>#2</td>
</tr>
</tbody>
</table>

- New students must have two completed Tuberculin skin tests (TST) if there is no documented proof of a positive TST in the past. The placement of the TSTs must be ≥ 7 days apart. **DATE/TIME of TST placement, DATE/TIME of TST read within 48-72 hours, and results recorded in “mm” MUST be recorded on the attached documentation or it is not valid!** One IGRA blood test (T-Spot or Quantiferon Gold) completed after May 1, 2017 may be substituted for the TSTs. If there is a known history of BCG vaccination, an IGRA blood test is preferred over TST placements.

#### TB Screening: TWO PPD skin tests are required if no history of positive TST OR one IGRA blood test may be substituted

- Step 1: (not >18 months before matriculation)  
- Step 2: (after May 1, 2017): **OR** IGRA (after May 1, 2017)

- If there is history of a positive TST or IGRA in the past, documentation/evidence of the positive result and evidence of any chest x-ray and medical treatment received must be provided. Also, for a newly positive TST or IGRA, evidence of a chest x-ray is required along with documentation of any medical treatment prescribed. A TB Symptom Questionnaire must also be completed (http://health.iupui.edu/employees/forms.html).

#### Positive History for TB Screening: If documented history of positive TST or IGRA, documentation/evidence of the positive result, Chest X-Ray, and completed TB Symptom Questionnaire are required

- Positive PPD skin test or IGRA: 
- Follow Up Treatment: Chest XR  
  Antibiotic Therapy (INH) taken?  
  Yes  No  
  TB Symptom Questionnaire
Indiana University Health Professions Programs
Student Health Evaluation

NAME: _________________________________________________  GENDER:   M   /   F     DATE OF BIRTH: _____/_____/_____    Graduating Class of: _______

(PLEASE PRINT LEGIBLY)

Family History:

Father:
□ Living (Age _____)
Occupation: ______________________
□ Deceased
Age at Death: _____
Cause: ______________________

□  Living (Age _____)

Mother:
□ Living (Age _____)
Occupation: ______________________
□ Deceased
Age at Death: _____
Cause: ______________________

□  Living (Age _____)

Siblings:
# Living  1   2   3   4   more

□  Deceased  1   2   3   4   more

Allergies:
__________________________          __________________________

Surgical History:
________________________________          ________________________________

Medication:
__________________________  __________________________

__________________________  __________________________

Have you or any of your relatives had any of the following? (Please include parents, grandparents, aunts, uncles, and siblings)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Y</th>
<th>Who, Explain</th>
<th></th>
<th>N</th>
<th>Y</th>
<th>Who, Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies - food, environment, medications</td>
<td></td>
<td></td>
<td></td>
<td>Musculoskeletal disease - arthritis, etc.</td>
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<td></td>
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<tr>
<td>Dermatological - eczema, psoriasis, etc.</td>
<td></td>
<td></td>
<td></td>
<td>Neurological - seizures, migraines, etc.</td>
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<tr>
<td>Gastrointestinal disease - GERD, UC, IBS, etc.</td>
<td></td>
<td></td>
<td></td>
<td>Obesity</td>
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<tr>
<td>GYN/GU - breast or prostate, etc.</td>
<td></td>
<td></td>
<td></td>
<td>Psychiatric - anxiety, depression, bipolar, etc.</td>
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<tr>
<td>Hematological - hemophilia, DVT, etc.</td>
<td></td>
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<td></td>
<td>Pulmonary disease - asthma, COPD, TB, etc.</td>
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<tr>
<td>Heart disease or high blood pressure</td>
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<td></td>
<td>Visual/Hearing Problem</td>
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<tr>
<td>Immunological - lupus, scleroderma, etc.</td>
<td></td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
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<td></td>
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</tr>
</tbody>
</table>

Lifestyle:

Diet:    Exercise:    Do you use any of the following?
□  Regular  □  Low Fat  □  None  □  Light  □  Yes
□  Vegetarian  □  Gluten-Free  □  Moderate  □  Heavy  □  Yes
□  Moderate  □  Heavy

Other: __________________________________________

Comments:                                                                                                        Other: _______________________________________________________

PHYSICAL EXAM

General Overall Appearance:

Height: ___________ Weight: ___________  BMI: ___________  Blood Pressure: ___________  Pulse: ___________  Respiratory Rate: ___________

Skin: ____________  Head: ____________   Eyes: ____________   Ears: ____________   Nose:  ____________   Throat: __________

Lymphadenopathy: ___________________________________  Neck: ___________________________________  Heart: ___________________________

Chest: ___________________________________  Spine: ___________________________________  Abdomen: ___________________________

Extremities: ___________________________________  Neurological:  __________________________________

Comments: ____________________________________________________________________________________________________________________

Laboratory Exam (if appropriate):

CBC:  Red Blood Count (RBC)  __________  Hemoglobin (Hgb) __________  Hematocrit (HCT) __________  White Blood Count (WBC) __________

Urineanalysis:  pH  Specific Gravity  Protein  Glucose  Bilirubin

PROVIDER EVALUATION

Student is determined to be physically and mentally able to attend:  □  Yes  □  No

Provider Recommendations: No: _____  Yes - explain:________________________________________________________________________________________

Limitations: No: _____  Yes - explain:______________________________________________________________________________________________________

Date: ______/_____/______  Signed: ________________________________________________  Printed: _______________________________________________

M.D/D.O. or N.P./P.A. Signature                                                            (Provider’s name printed)