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 ARE 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, School, 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:**

   - **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.*

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

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

   - **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:**

     | Date Placed | Time Placed | PPD Lot # | Exp Date | Location | Placed By: | Date Read | Time Read | Results (mm) | Read By: |
     |-------------|-------------|-----------|---------|----------|------------|-----------|-----------|-------------|---------|
     | 02/16/13    | 1250        | 123456    | 12/2015 | RFA      | MER, RN    | 02/18/13  | 1327      | 0mm         | TPW, LPN |
     | 07/01/13    | 1501        | 123456    | 12/2015 | LFA      | RAF, RN    | 07/04/13  | 1246      | 0mm         | ANG, RN  |

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) must also be completed and submitted with your documentation.

**FYI – All students will be required to participate in annual academic year TB Surveillance, TB Respirator FIT Testing, and Flu vaccination while attending IU School of Medicine.**

You will be contacted via email once your documentation is received and reviewed.
School of Medicine  
2017 Student Immunization Checklist

Name (PRINT LEGIBLY): ____________________ ____________________ _____ Date of Birth: _____/_____/____

Gender: M / F Student ID#:________________________ Phone:(_____)____________________

Program Start Date: ___/___/___ Graduating Class of: __________ Email:________________________

Declaration Statement

IUPUI Campus Health and the School require you to provide documentation of the following vaccinations. **Failure to submit the appropriate documentation may delay or prevent your ability to start your program.** We highly recommend you submit your documentation as early as possible. We are not responsible if you submit documentation at the last minute that does not meet requirements.

**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)

Vaccinations: #1 #2 #3 OR Evidence of Immunity: Hepatitis B Titer

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

Vaccinations: #1 #2 OR Evidence of Immunity: Measles Titer Mumps Titer Rubella Titer

Tdap (Tetanus/Diptheria and Acellular Pertussis): ONE dose (first available in 2005) is required. Td boosters every 10 years.

Vaccination: #1

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**

Vaccinations: #1 #2 OR Evidence of Immunity: Varicella Titer

- 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

Step 1: (not >18 months before matriculation) OR Step 2: (After May 1st, 2017): 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

IUPUI Campus Health Patient Portal Pre-Registration Instructions
Indiana University School of Medicine
Student Health Evaluation

NAME: _________________________________________________  GENDER:   M   /   F     DATE OF BIRTH: _____/_____/_____   IUSM Class of: _________

(PLEASE PRINT LEGIBLY)

Family History:
Father:
- □ Living (Age _____)
- □ Deceased

Mother:
- □ Living (Age _____)
- □ Deceased

Siblings:
- □ Living (Age _____)
- □ Living (Age _____)
- □ Deceased

Occupation: ____________________________________________

Age at Death: ____

Cause: ______________________

Allergies:
__________________________          __________________________       __________________________       __________________________

Surgical History:
________________________________       ________________________________          ________________________________

Medication:
__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

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

Allergies - food, environment, medications

□ N Y Who, Explain

Musculoskeletal disease - arthritis, etc.

□ N Y Who, Explain

Dermatological - eczema, psoriasis, etc.

□ N Y Who, Explain

Neurological - seizures, migraines, etc.

□ N Y Who, Explain

Gastrointestinal disease - GERD, UC, IBS, etc.

□ N Y Who, Explain

Obesity

□ N Y Who, Explain

GYN/GU - breast or prostate, etc.

□ N Y Who, Explain

Psychiatric - anxiety, depression, bipolar, etc.

□ N Y Who, Explain

Hematological - hemophilia, DVT, etc.

□ N Y Who, Explain

Pulmonary disease - asthma, COPD, TB, etc.

□ N Y Who, Explain

Heart disease or high blood pressure

□ N Y Who, Explain

Visual/Hearing Problem

□ N Y Who, Explain

Immunological - lupus, scleroderma, etc.

□ N Y Who, Explain

Other

□ N Y Who, Explain

Kidney Disease

□ N Y Who, Explain

Lifestyle:
Diet: ______________________  Exercise: ______________________  Do you use any of the following?

□ Regular  □ Low Fat  □ None  □ Light  □ Tobacco  □ No  □ Yes  □ Alcohol  □ No  □ Yes

□ Vegetarian  □ Gluten-Free  □ Moderate  □ Heavy  □ Seat Belts  □ No  □ Yes  □ Caffeine  □ No  □ Yes

□ Comments: ____________________________________________________________________________________________________________________

□ Other: __________________________________________________________

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) __________

Urinalysis:  pH __________  Specific Gravity __________  Protein __________  Glucose __________  Bilirubin __________

PROVIDER EVALUATION

Student is determined to be physically and mentally able to attend medical school:  □ 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 pri