Indiana University School of Medicine Health Requirements for Matriculation

For the protection of students and the patients with whom they will come in contact during training, all entering medical students must meet established health requirements.

HEALTH FORMS AND IMMUNIZATION DOCUMENTATION ARE DUE June 30th!

Please print the Health Evaluation and Immunization Checklist forms, ensure all required and applicable documentation is attached, and send the documents to IUPUI Campus Health as follows:

Scanning: healthsv@iupui.edu  OR  Fax: 317-278-6929

*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:** 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 lifetime booster as an adult is required. The TDaP vaccination was first available in 2005.

- **Varicella (Chicken Pox)** – Proof of 2 vaccinations at least 28 days apart OR proof of an immune Varicella antibody titer is required. Having 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 at least 7 days apart. Step 1 must be within 18 months of matriculation and step 2 must be after May 1st of the year of matriculation. One interferon gamma release assay (IGRA) completed after May 1st may be substituted for the 2 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>1237</td>
<td>0mm</td>
<td>MER, RN</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://studentaffairs.iupui.edu/health-wellness/student-health/forms/index.shtml](http://studentaffairs.iupui.edu/health-wellness/student-health/forms/index.shtml)) 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.

**INCOMPLETE PACKETS ARE NOT ACCEPTABLE**

You will be contacted via email once your documentation is received and reviewed.
IUPUI
School of Medicine
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 by June 30th.
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**

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Requirement</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td>THREE doses are required OR a positive antibody titer (HBsAb)</td>
<td><strong>Note:</strong> Having the disease as a child is not proof of immunity**</td>
</tr>
<tr>
<td>MMR (Measles, Mumps, Rubella)</td>
<td>TWO doses are required at least 28 days apart OR a positive antibody titer (IgG) for each</td>
<td></td>
</tr>
<tr>
<td>TDaP (Tetanus/Diptheria and Acellular Pertussis)</td>
<td>ONE adult dose first available in 2005 is required within the last 10 years</td>
<td></td>
</tr>
<tr>
<td>Varicella (Chicken Pox)</td>
<td>TWO doses are required at least 28 days apart OR a positive antibody titer (IgG)</td>
<td></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 1st 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 1st of year of matriculation): | OR an IGRA after May 1st |

• 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://studentaffairs.iupui.edu/health-wellness/student-health/forms/index.shtml).

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

<table>
<thead>
<tr>
<th>Positive PPD skin test or IGRA:</th>
<th>Follow Up Treatment:</th>
<th>Antibiotic Therapy (INH) taken?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chest XR</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Rev 04/23/2015
Indiana University School of Medicine
Student Health Evaluation

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

(PLEASE PRINT LEGIBLY)

Family History:
Father:     Mother:     Siblings:
□  Living (Age _____)  □  Living (Age _____)  # Living 1 2 3 4 more
Occupation: ______________________  Occupation: ______________________  # Deceased 1 2 3 4 more
□  Deceased  □  Deceased
Age at Death: ______  Age at Death: ______
Cause: ______________________  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)

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

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
□  Moderate  □  Heavy
Caffeine □  No □  Yes

Comments: ____________________________________________________________________________________________________________________

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) __________
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 printed)
IUPUI Campus Health Patient Portal Pre-Registration

It is important that the steps below are completed in chronological order.

PLEASE NOTE: If you have already been a patient at our clinic, you do not need to pre-register. To web-enable your account, either send an email to healthsv@iupui.edu or call 317-274-8214 with your request. Once web-enabled, you can review and/or update your information following steps 3 – 6 below.

1. Pre-Register as a patient by going to IUPUI Campus Health’s Patient Portal using the following link: https://health.eclinicalworks.com/IUPUCampusHealth. Click the Pre-Register button.

![Pre-Register button](image1.png)

2. Fill out the starred demographic information in all three tabs and click ‘Submit’ when finished. You must provide an iupui.edu, iu.edu, or indiana.edu email address during registration to be web-enabled! If you do not have an iupui.edu, iu.edu, or indiana.edu address, enter your current email address and skip to step 6.

![Form Fields](image2.png)

3. IUPUI Campus Health will process your submitted registration, which may take several days. After your registration is complete, IUPUI Campus Health will send you an email with your username and temporary password to log into the IUPUI Campus Health Patient Portal. Once you receive your portal access credentials, log into the Patient Portal to complete the next step. Your temporary password will expire in 48 hours. If your password expires, either send an email to healthsv@iupui.edu or call 317-274-8214 requesting it be reset.
4. When logged into the Patient Portal, click “Immunizations Given in the Past” under Questionnaires located on the left hand side.

5. Complete the date fields (free text or use the calendar) next to the vaccines that you have received. Leave date fields blank if you have not had that vaccine. When finished, click Submit. (Any titers, TB Surveillance, and/or additional vaccinations will be entered by our office once your completed immunization packet and supporting documentation are received.)

6. Print and complete the applicable “Student Immunization Checklist”, and then fax the checklist and all supporting documents to 317-278-6929 or scan to healthsv@iupui.edu. Please be sure to include your last name, first name, school, and graduating class in the subject line. You will receive an email once your documentation is received and reviewed.