



STUDENT HEALTH SERVICE  
 ARTHUR ASHE STUDENT HEALTH AND WELLNESS CENTER  
 BOX 951703  
 LOS ANGELES, CALIFORNIA 90095-1703

Dear Medical Student,

The David Geffen School of Medicine at UCLA requires that you obtain a health clearance. The enclosed "Health Screening Requirements" must be completed by Orientation week, August 1, 2005 in order to fulfill the David Geffen School of Medicine at UCLA mandate. Please note the requirements listed below must be completed within the time frame as noted below.

1. **Tuberculosis Skin Test (PPD/Mantoux)** – within 6 months of entry to school. If your PPD is reactive (positive), or you have a history of a reactive PPD, a chest x-ray is required within 6 months of entry to school.
2. **Tetanus/diphtheria** – within 10 years
3. **Measles, Mumps, Rubella** – Positive MMR titers to show immunity. If titer negative, proof of post titer vaccination.
4. **Hepatitis B** – Laboratory evidence of immunity OR written documentation of Hepatitis B immunization series begun. 2 doses of vaccine documented prior to entry to school. The 3<sup>rd</sup> dose is required 6 months after the first dose.
5. **Varicella** – Positive titer to show immunity, or 2 doses of vaccine.

**How to obtain a health clearance:**

**Plan A:** You may choose to have the health clearance form completed by your health care provider. If you choose to use your own health care provider, the form must be mailed to the UCLA - Arthur Ashe Student Health & Wellness Center no later than August 1, 2005. Please note that the forms must be completed entirely, including all immunization dates and /or titers and results. The mail in address is:  
**UCLA - Arthur Ashe Student Health Center/Attention Health Clearance/Medicine**  
**BOX 951703**  
**Los Angeles, CA 90095-1703**

**Plan B:** You may also have the health clearance form and some or all of the requirements completed at the UCLA - Arthur Ashe Student Health & Wellness Center. Without SHIP insurance, you will be charged \$30 for the initial health clearance appointment. You are also responsible for the cost of any lab and immunization fees. Price lists are enclosed so you can anticipate the cost of services needed. To make an appointment at the UCLA - Arthur Ashe Student Health & Wellness Center, call **310-825-4073**.

**Please verify with the School of Medicine that the above requirements have been completed.** The health clearance is required because your immunization and health status will be required by any medical institution in whose program you participate during your education. Also, as you continue your education in the health care field, it is vitally important that you be attentive to your own health needs as well.

Sincerely,  
 Bettina Pedone, RN, MSN, FNP  
 Health Clearance Coordinator UCLA - Arthur Ashe Student Health & Wellness Center  
 Voicemail: 310-794-1910 Fax : 310-267-1996  
 Email: [bpedone@ashe.ucla.edu](mailto:bpedone@ashe.ucla.edu)

Price list (prices are subject to change without notice, charges will automatically be billed to BAR)

TB skin test - free      Tetanus/diphtheria - \$31      Hepatitis B vaccine - \$37/each

MMR vaccine \$51    Varicella titer \$18\*    Varicella vaccine \$77/each

Rubeola titer - \$6.78\*    Rubella titer - \$20.11\*    Mumps titer - \$25\*

Hep BsAb titer \$15\*    HepBcAb titer \$16.84\*    HepBsAg titer \$14.43\*

**\* Plus \$6.00 lab handling fee for each test**

# The David Geffen School of Medicine at UCLA Health Screening Requirements

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Student ID#: \_\_\_\_\_ Birth date: \_\_\_\_\_

Class of \_\_\_\_\_ Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

## **Health History:**

(This form is to assist the medical practitioner in assessing your ability to perform the essential functions of the program in which you are enrolled, determining whether accommodations are appropriate or required, and obtaining information as to your need for special or emergency medical procedures.)

Relative to your program, is there any health-related condition for which you require accommodation? (i.e. job modification, structural changes to work area etc..) If so, please list below: \_\_\_\_\_

---

In order to assist the healthcare provider in assessing your ability to perform the essential functions of the program in which you are enrolling, or the need for reasonable accommodations, please complete the following:

**Illnesses** – Check NO or YES. If yes, indicate date(s) of occurrence:

	NO	YES	Date
1. Any skin or other health-related condition which causes recurrent eczema, irritated skin or open skin lesions	___	___	_____
2. Hearing problems (loss of hearing, ringing of the ears, other)	___	___	_____
3. Vision problems (glaucoma, cataract, color blindness, other)	___	___	_____
4. Difficulty breathing (shortness of breath, or chronic cough)	___	___	_____
5. Hernia	___	___	_____
6. Chronic or recurring pain or limited motion associated with: (describe)			
a. Neck: _____	___	___	_____
b. Arm: _____	___	___	_____
c. Wrist: _____	___	___	_____
d. Hand: _____	___	___	_____
e. Back: _____	___	___	_____
f. Other: _____	___	___	_____
7. Heart Condition or Heart Disease	___	___	_____
8. Seizure disorder (epilepsy or other)	___	___	_____
9. Diabetes	___	___	_____

**Allergies:** Have you ever had a reaction, allergy, and or sensitivity to any drugs (such as codeine, penicillin, or sulfa), food, LATEX, plants or chemical? If yes, specify substance and reaction: \_\_\_\_\_

## **Medications:**

Are there any other medications or any medical conditions we should know about in order to provide you with necessary emergency or medical care? No \_\_\_ Yes\_\_\_

If yes, please record here: \_\_\_\_\_

Do you take any medications which could affect your physical or mental function or performance? No\_\_\_ Yes\_\_\_

If yes, please explain: \_\_\_\_\_

## **Other:**

Do you wish to discuss any other education/program related health condition or problem? No \_\_\_ Yes\_\_\_

If yes, please record here: \_\_\_\_\_

**Certification:** I hereby certify that the answers given by me to the foregoing question and statements are true and complete and without omissions. I understand that if any false statements of material fact or omissions on this form may be considered sufficient cause for dismissal. I authorize the UCLA - Arthur Ashe Student Health & Wellness Center to release information regarding this Health Clearance to The David Geffen School of Medicine at UCLA. This release is valid through \_\_\_\_\_ (date of graduation).

\_\_\_\_\_(signature) \_\_\_\_\_(date)

**The David Geffen School of Medicine at UCLA Health Screening Requirements  
Immunization/Infectious Disease Status**

Name: \_\_\_\_\_

Student ID#: \_\_\_\_\_

Birth date: \_\_\_\_\_

**Ashe use only**

1. **TB skin test (PPD)** Date: \_\_\_\_\_ result: \_\_\_\_\_ mm induration (within 6 months if non reactive) \_\_\_\_\_  
CXR date \_\_\_\_\_ result: \_\_\_\_\_ (must be within 6 months if PPD reactive) \_\_\_\_\_

2. **Tetanus/diphtheria (within 10 years)** \_\_\_\_\_

3. **Rubeola (measles) Titer** \_\_\_\_\_  
Results: Positive \_\_\_\_ (date) \_\_\_\_\_ Negative \_\_\_\_ (date) \_\_\_\_\_  
Post titer vaccine if titer negative: \_\_\_\_\_ (date)

4. **Mumps Titer** \_\_\_\_\_  
Results: Positive \_\_\_\_ (date) \_\_\_\_\_ Negative \_\_\_\_ (date) \_\_\_\_\_  
Post titer vaccine if titer negative: \_\_\_\_\_ (date)

5. **Rubella (German measles)** \_\_\_\_\_  
Results: Positive \_\_\_\_ (date) \_\_\_\_\_ Negative \_\_\_\_ (date) \_\_\_\_\_  
Post titer vaccine if titer negative: \_\_\_\_\_ (date)

6. **Varicella (Chickenpox)** \_\_\_\_\_  
Results: Positive \_\_\_\_ (date) \_\_\_\_\_ Negative \_\_\_\_ (date) \_\_\_\_\_  
Post titer vaccine if titer negative: \_\_\_\_\_ (date)

OR

Written documentation showing adequate vaccination:

1<sup>st</sup> dose (first dose given) \_\_\_\_\_ (date)

2<sup>nd</sup> dose (4-6 weeks later) \_\_\_\_\_ (date)

**7. Hepatitis B Requirement**

Written documentation of Hepatitis B immunization program begun: \_\_\_\_\_

1<sup>st</sup> dose (first dose given) \_\_\_\_\_ (date)

2<sup>nd</sup> dose (1 month after 1<sup>st</sup> dose) \_\_\_\_\_ (date)

3<sup>rd</sup> dose (6 months after 1<sup>st</sup> dose) \_\_\_\_\_ (date)

Hepatitis B core Antibody (*Required* if Hep B vaccine is not given)

Results: Positive \_\_\_\_ (date) \_\_\_\_\_ Negative \_\_\_\_ (date) \_\_\_\_\_

Hepatitis B surface Antigen (*Required* if Hep BcAb positive)

Results: Positive \_\_\_\_ (date) \_\_\_\_\_ Negative \_\_\_\_ (date) \_\_\_\_\_

Hepatitis B surface Antibody (*Required one month after all 3 vaccines  
in series completed* and if Hep BcAb (+) and Hep BsAg negative)

Results: Positive \_\_\_\_ (date) \_\_\_\_\_ Negative \_\_\_\_ (date) \_\_\_\_\_

Infectious disease status reviewed and up to date \_\_\_\_ (check if complete)

Signature of Clinician: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address of Clinician: \_\_\_\_\_

---

**Ashe use only**

Date of submission: \_\_\_\_\_

Requirements needed before clearance: \_\_\_\_\_ Initials: \_\_\_\_\_

\_\_\_\_ Infectious Disease status reviewed and Health Clearance requirements met.

\_\_\_\_ Other: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_