Dear Student:

A complete health history, physical examination, serum blood titers, Tuberculosis clearance, immunization records (since childhood), a Tdap vaccine and completion of all the attached forms is required prior to registration at Western University of Health Sciences (WesternU). Once you have completed all of the above requirements forward all of the documents to the Student-Employee Health Coordinator (see below).

**NOTE:** You should only need to contact our office if you have not received an email or phone call from our department within 10 business days after you have submitted your health clearance documents. Contact information is below.

YOU WILL NOT BE ALLOWED TO COMPLETE THE REGISTRATION PROCESS WITHOUT PROVIDING THE FOLLOWING COMPLETED DOCUMENTS:

1. Student Information (Form A—1 page)
2. Health History (Form B—1 page)
3. Physical Examination (Form C—2 pages; your healthcare provider must sign this form)
4. Immunization records / titer results & Tuberculosis (TB) clearance (Form D—2 pages—your healthcare provider must sign this form)
5. Authorization for release of communicable disease clearance information to clinical rotation sites (1 page and you must sign and date this form)
6. Authorization for release of student health clearance documents (1 page and you must sign and date this form).

All documents must contain your name and WesternU Student ID number.

RETURN ALL COMPLETED FORMS (via mail, fax or email) TO:

Western University of Health Sciences
Student Health Office
100 W. Second Street, Anderson Tower, Room 219
Pomona, CA 91766-1700
Email: stu-emphealth@westernu.edu
Or
Main #: 909-706-3830 / Fax #: 909-706-3785
HEALTH CLEARANCE “TO DO” LIST

Take the Health Clearance Packet and forms with you every time you visit your Healthcare Provider:

1st appointment with your Healthcare Provider (can only be: MD/DO/NP/PA):
- Physical Examination (Form C): make sure form is completely filled out and signed by your Healthcare Provider.
- Order the following serum blood titers (any quantitative result must have reference ranges to be accepted):
  - Hepatitis B (HBsAb, QN)  
    Can be either Qualitative or Quantitative [if QN, must include reference range numbers]
    [NOTE: only a QUANTITATIVE result will be accepted]
  - Varicella (Varicella AB, IgG).
  - Measles (Measles AB, IgG, EIA)
  - Mumps (Mumps AB, IgG)
  - Rubella (MMR AB, IgG)
  - A Tdap vaccine obtained within the last 10 years. A TD or DTap will not be accepted.
- Tuberculosis Clearance must be one of the following:
  - 1st TB skin test administered and must be read after 48 to 72 hours after administration.
  - IGRA, e.g., Quantiferon or T-spot Test (valid at WesternU for 4 years) instead of TB skin tests will be accepted.
  - Chest x-ray only if you have history of positive TB skin test or if your IGRA test is positive.

2nd appointment with your Healthcare Provider:
- Review titer results and obtain copy of all actual lab and, if needed, Chest X-ray reports.
- Receive Hepatitis B, MMR, and/or Varicella vaccine, if indicated, and provide documentation.
- Form D completed and signed by your Healthcare Provider.
- Tuberculosis Clearance must be one of the following:
  - TB skin test: result must be a number. The words “negative” or “positive” will not be accepted.
  - IGRA: (e.g., Quantiferon or T-spot) test lab report and completed TB Symptoms Health Screening Checklist form, signed/dated by your Healthcare Provider.
  - Chest x-ray: radiology report and completed TB Symptoms Health Screening Checklist form, signed/dated by your Healthcare Provider.

Obtain copies of all your immunization records since childhood from your doctor’s office, high school, or previous university.

Gather all your health clearance documents and ONLY the following are to be sent to Student Health:
- Forms A through D, completed, signed and dated
- Copies of all titers and other required lab results
- Copies of all immunization records since childhood
- TB clearance as described in item #2

Send one complete copy of all your documents at one time via fax, email, or regular mail.
Do not send your forms a few pages at a time as they can be misplaced.
Do not depend on your healthcare provider’s office sending all your forms to us.
Please carefully read the details below regarding the documentation you must provide in order to register for classes.

1. **History and physical exam:** must be within six (6) months of matriculation (first day of beginning your classes at WesternU). (Complete Forms A through C, be sure they are complete and signed as indicated or they will not be accepted).

2. **Serum blood titer reports:** must be drawn within one (1) year of matriculation and show you are immune against measles, mumps, rubella, varicella and Hepatitis B. Immunization records and/or “had the disease” alone will not be accepted for these diseases. You must submit serum titer lab results that include reference ranges, along with your immunization records. These records must show, at minimum, your name, the name of the vaccine and the date of administration.
   a. Your healthcare provider **MUST ORDER THE FOLLOWING** titers to meet this admission requirement:
      1. Hepatitis B Surf AB QN (only Quantitative results will be accepted, must include reference range numbers)
      The lab results for the following can be either Qualitative (QL) or Quantitative (QN).
      2. Measles AB IGG, EIA
      3. Rubella Antibodies, IgG
      4. Mumps Antibodies, IgG
      5. Varicella IgG AB
      6. IGRA (e.g., Quantiferon or T-spot)
   b. Based upon your health history or current health status, if a particular immunization is medically (temporarily/permanently) contraindicated, a signed letter from your licensed healthcare provider attesting to this contraindication will be acceptable. However, you will still be responsible for obtaining the immunization clearance as soon as your temporary health issue is resolved. You will not be cleared to start any clinical rotations without this clearance.

3. **Hepatitis B vaccine series:** if you have initiated the Hepatitis B vaccination series prior to starting classes, but have not yet completed the series of three (3) injections, registration for your first semester of classes will not be delayed. If you submit documentation showing you have started the Hepatitis B vaccination series. However, you will need to submit proof of receiving the 2nd and 3rd vaccine as soon as they have been received. You must also provide a Hepatitis B Surf AB QN titer, that was drawn at least 30-days after your 3rd vaccine.

4. **Tetanus/Diphtheria/Acellular Pertussis (Tdap) booster:** we require one documented Tdap booster within the last 10 years. An immunization record is required for this vaccination.

5. **Tuberculosis (TB) clearance:** **YEARLY REQUIREMENT** NOTE: If you need to have the 2-step (meaning 2 separate) PPD skin test, they must be at least 10 days apart or they will not be accepted. If you are on the Pomona campus, you can obtain your 2nd PPD skin test during the first week of classes at the Patient Care Center Pharmacy on the east end of campus. **It is your responsibility to renew your yearly TB clearance and submit it to Student Health before it expires.** The only acceptable TB clearance is one of the following:
   a. **Tuberculin Skin Test (commonly known as a PPD):** PPD results must be read 48- to 72-hours after administration and the results must indicate millimeters of induration and not simply “negative” or “positive.” The form must be dated and signed by a licensed healthcare provider or it will not be accepted.
   b. **IGRA lab test:** reports cannot be more than 6 months from date of matriculation and must indicate qualitative results. **This blood test is valid at WesternU for four (4) years,** however students must also submit a completed, signed and dated TB Symptoms Health Screening checklist form on a yearly basis to the Student Health Office.
   c. **Chest x-ray:** If you have a prior history of latent TB infection (LTBI) as determined through a tuberculin skin test (PPD) or a blood test (IGRA), a licensed Healthcare Provider must provide a signed, written report that shows you do not have active TB disease. If you were treated with medication for LTBI, the name, dosage, duration, and date of completion must also be included. If a chest x-ray was required for TB clearance, a copy of the actual radiology report and a completed TB Symptoms Health Screening checklist form must accompany your health clearance documents. Please note that the chest x-ray cannot have been taken more than **6-months** prior to the start of your matriculation (first day of class), this way it is valid for four (4) years.
**Immunization, Health History and Physical Examination Information**

**Prior history of active pulmonary TB:** A licensed physician must provide a signed, written report that must show you have completed, or are in the process of completing, all required therapy. The report must include the name of the medications, dosages, frequency of administration, and total doses received. If you have completed the therapy, the report must state this fact, including the date the treatment was completed. If your treatment is still in process, the report must state when it is expected to be completed. Additionally, a chest x-ray report is required for admission clearance. You must provide a copy of the actual radiology report and it cannot be more than 6-months old if: 1) you have completed the treatment and/or 2) from the day you start class.

**History of BCG vaccination:** Prior BCG vaccination is NOT a contraindication to either PPD or IGRA. In this setting, interpretation of the results of screening tests for TB infection will take into account each of the following: 1) the length of time between past BCG vaccination and the screening test; and 2) the risk of infection with Mycobacterium tuberculosis.

6. **Influenza vaccination:** **YEARLY REQUIREMENT**—All students must receive the annual influenza vaccination every fall. Documentation of receipt of this vaccination is required and must be submitted to the Student Health Office no later than the November 30th each year or a hold will be placed on your account.

    **Veterinary Students ONLY**

7. **Rabies vaccination:** Students enrolling in the DVM program must provide all of the above documentation as well as show proof of having received the pre-exposure series of rabies immunization, or agree to complete the rabies vaccinations as part of the University matriculation process no later than September 30th of the current year.
   a. A pre-exposure series involves the administration of three (3) intramuscular doses of the vaccine given on days 0, 7 and 21 or 28.
   b. You can begin receiving your rabies vaccination series now or during orientation week on campus at the Patient Care Center Pharmacy. A fee is charged for each of the vaccines you have to receive. For pricing, please call 909-706-3730.
   c. Students who have previously received the Rabies vaccine series may be excused from being re-vaccinated by providing official documentation from their healthcare provider stating the dates they received all 3 rabies vaccines. The serum RFFIT titer (which measures level of immunity to rabies) must be done two years after completing a rabies vaccines series. If the vaccines were completed more than 2 years ago, you will need to obtain a RFFIT serum titer. The titer results must also be included in the documentation you will be sending in.

**KEY POINTS**

No further health clearance reminders will be sent to you. It is your responsibility to keep track of items you are required to submit to the Student Health Office.

If you fail to submit required documents when they are due, a hold will be placed on your account. This means you will not be able to register for classes, receive financial aid payments, or obtain transcripts.

All records/documents submitted must be either originals or clean and clear copies. They must also contain your name, WesternU Student ID #, the college/program in which you will be enrolled, and your anticipated graduation year must be clearly written on each document, e.g., John Smith, @0012345678, COMP 2022.

If you have medical questions on any of the above, please consult with your personal physician or healthcare provider.

If you have any additional question regarding the health clearance requirements, you may direct them to the Student Health Office at 909-706-3830. You can also email us at: stu-emphealth@westernu.edu
Form A: Student Information
This section to be completed by the student. Please use ink and print clearly.

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Sex (circle):</th>
<th>WesternU Student ID#</th>
<th>Anticipated Year of Graduation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
<td>Middle</td>
<td>Male</td>
<td>Female</td>
</tr>
</tbody>
</table>

Program (indicate the college you will be entering)

<table>
<thead>
<tr>
<th>COMP-DO: California</th>
<th>College of Allied Health: PT</th>
<th>College of Allied Health: PA</th>
<th>College of Graduate Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMP-DO: Oregon</td>
<td>College of Pharmacy</td>
<td>College of Veterinary Medicine</td>
<td>College of Podiatry</td>
</tr>
<tr>
<td>College of Dentistry</td>
<td>College of Optometry</td>
<td>College of Biomedical Sciences</td>
<td></td>
</tr>
</tbody>
</table>

Current Address:

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip/Province Code</th>
</tr>
</thead>
</table>

Telephone Number: ___________________________  WesternU Email: ______________________@westernu.edu

Person to notify in case of an emergency/accident:

Name: ___________________________  Relationship: ___________________________

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle Initial</th>
</tr>
</thead>
</table>

Address:

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State/Country</th>
<th>Zip/Province Code</th>
</tr>
</thead>
</table>

Telephone: ___________________________  Cell: ___________________________

(Please include country code if telephone numbers are outside of the United States)

Email: ___________________________

Signature of Student / Date Signed
**Form B: Health History**

This section to be completed by the student. Please use ink and print clearly.

**Name: ___________________________  WesternU Student ID# @ ___________________________**

Allergies (drugs/food): ___________________________________________________________

Medications currently taking: ____________________________________________________

<table>
<thead>
<tr>
<th>Place a check mark if you currently or have ever had any of the following:</th>
<th>GASTROINTESTINAL</th>
<th>BLOOD DISORDER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEAD</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major dental problems</td>
<td>Abdominal pain</td>
<td>Anemia</td>
</tr>
<tr>
<td>Dizziness or Fainting</td>
<td>Recent changes in appetite</td>
<td>Rheumatic fever</td>
</tr>
<tr>
<td>Encephalitis</td>
<td>Recent changes of bowel habits</td>
<td>Sickle cell</td>
</tr>
<tr>
<td><strong>EYES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye trouble</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wear glasses</td>
<td>Digestive disorder</td>
<td></td>
</tr>
<tr>
<td>Wear Contact Lenses</td>
<td>Difficulty swallowing</td>
<td></td>
</tr>
<tr>
<td><strong>EARS/NOSE/THROAT</strong></td>
<td>Recurrent emesis (vomiting)</td>
<td>Frequent nightmares</td>
</tr>
<tr>
<td>Allergies</td>
<td>Gastric or duodenal ulcer</td>
<td>Trouble concentrating</td>
</tr>
<tr>
<td>Ear trouble</td>
<td>Hemorrhoids/Rectal fissures</td>
<td>Cry often</td>
</tr>
<tr>
<td>Hearing problem</td>
<td>Other ano-rectal disorder</td>
<td>Feeling of depression</td>
</tr>
<tr>
<td>Frequent nosebleeds</td>
<td>Hernia</td>
<td>Tendency to worry</td>
</tr>
<tr>
<td>Hay fever</td>
<td>Intestinal worms</td>
<td>Memory loss</td>
</tr>
<tr>
<td>Frequent sore throat</td>
<td>Jaundice</td>
<td>Mental health disorder</td>
</tr>
<tr>
<td><strong>ENDOCRINE</strong></td>
<td></td>
<td></td>
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<tr>
<td>Hypothyroid</td>
<td>Black bowel movements</td>
<td></td>
</tr>
<tr>
<td>Hyperthyroid</td>
<td>Vomiting blood</td>
<td>Considerable nervousness</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>Intestinal inflammation</td>
<td>Difficulty sleeping</td>
</tr>
<tr>
<td><strong>CHEST/HEART/LUNGS/VASCULAR</strong></td>
<td>Gall bladder disease</td>
<td>Considered suicide</td>
</tr>
<tr>
<td>Breast disease or masses</td>
<td>Hepatitis</td>
<td>Lose temper often</td>
</tr>
<tr>
<td>Chest pain/purpose</td>
<td>Urine contains (circle): Blood</td>
<td>Require use of sleeping aids</td>
</tr>
<tr>
<td>Heart disease/murmur</td>
<td>Albumin</td>
<td>Other</td>
</tr>
<tr>
<td><strong>INFECTION</strong></td>
<td>Kidney disease</td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Bladder disease</td>
<td>Cancer</td>
</tr>
<tr>
<td>Rapid or irregular pulse</td>
<td>Painful urination</td>
<td>Unusual fatigue</td>
</tr>
<tr>
<td>Varicose veins</td>
<td>Frequent urination</td>
<td>Frequent colds</td>
</tr>
<tr>
<td>Asthma</td>
<td>Genital disorder</td>
<td></td>
</tr>
<tr>
<td>Chronic cough</td>
<td>Prostate gland disorder</td>
<td>Sexual problems</td>
</tr>
<tr>
<td>Emphysema</td>
<td>Frequent urinary tract infections</td>
<td>Skin disorders/infections</td>
</tr>
<tr>
<td>Lung disease</td>
<td>Other</td>
<td>Unexplained weight gain or loss</td>
</tr>
<tr>
<td>Night sweats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pleurisy</td>
<td>Abnormal pap smear</td>
<td>Other</td>
</tr>
<tr>
<td>Wheezing</td>
<td>Ovarian cysts</td>
<td>Appendectomy</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>Pelvic inflammatory disease (PID)</td>
<td>Gall bladder</td>
</tr>
<tr>
<td>Coughing up blood</td>
<td>Pregnancy: G P</td>
<td>Pelvic surgery</td>
</tr>
<tr>
<td><strong>INFECTIOUS DISEASE</strong></td>
<td>Painful menses (dysmenorrhea)</td>
<td>Cesarean section</td>
</tr>
<tr>
<td>Amebiasis</td>
<td>Fibrocystic disease</td>
<td>Tomillectomy</td>
</tr>
<tr>
<td>Chicken pox</td>
<td>Other</td>
<td>Other</td>
</tr>
<tr>
<td>Coccidiodymositis (Valley Fever)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encephalitis</td>
<td></td>
<td></td>
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<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
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<tr>
<td>Histoplasmosis</td>
<td></td>
<td></td>
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<tr>
<td>Intestinal Parasitic infection</td>
<td>Arthritis</td>
<td>Recreational drug use</td>
</tr>
<tr>
<td>Malaria</td>
<td>Chronic muscle pain</td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td>Spine problem, e.g., disc or vertebrae</td>
<td>Other</td>
</tr>
<tr>
<td>Meningitis</td>
<td>Swollen or painful joints/extremities</td>
<td>Please explain any areas that you checked or may not be</td>
</tr>
<tr>
<td>Mononucleosis</td>
<td>Bone infection</td>
<td></td>
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<tr>
<td>Mumps</td>
<td></td>
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<tr>
<td>Prior BCG vaccine</td>
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<tr>
<td>Prior positive PPD</td>
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<td></td>
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<tr>
<td><strong>NEUROLOGICAL</strong></td>
<td></td>
<td></td>
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<tr>
<td>Rheumatic fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td>Speech defect</td>
<td></td>
</tr>
<tr>
<td>Scarlet fever</td>
<td>Cluster headache</td>
<td></td>
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<tr>
<td>Sexually transmitted disease</td>
<td>Migraine headaches</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Paralysis, tremors, muscle weakness</td>
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<tr>
<td></td>
<td>Neurailgia or numbness</td>
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<tr>
<td></td>
<td>Seizures</td>
<td></td>
</tr>
</tbody>
</table>
**Name:** ________________________________  **WesternU Student ID#:** ________________________________

**Date of Exam:** ________________________________

**Ht:** ________  **Wt:** ________

**BP:** _______/______  **Pulse:** ________  **Resp:** ________  **Vision:** R _______/20  L _______/20  **Corrected** / **Uncorrected** (circle)

**GENERAL:**
Posture, gait, speech, appearance

**HEAD:**
Hair, symmetry, tenderness

**EYES:**
Lids, sclera, conjunctiva, muscles, cornea, pupils, fundi, peripheral fields

**EARS:**
Pinna, canal, drum, hearing

**NOSE:**
Septum, obstruction, mucosa

**MOUTH/THROAT:**
Breath, lips, teeth, tongue, mucosa, pharynx, tonsils

**NECK:**
Thyroid, motion, trachea, veins

**LYMPHATICS:**
Cervical, supraclavicular, axillary, inguinal

**CHEST/LUNGS:**
Symmetric, percussion, excursion, breath sounds

**CARDIOVASCULAR:**
PMI, Rate, Rhythm, Sound, Murmur, Neck Bruits, upper ext. pulses, lower ext. pulses, leg veins, edema, abdominal bruit

**ABDOMEN:**
Tenderness, organs, hemia, masses, sounds, scars

**MUSCULOSKELETAL:**
Back, upper extremities, lower extremities

**SKIN:**
Birthmarks, rashes, scars, texture

**NEUROLOGIC:**
DTRs: Biceps, Triceps, Patella, Ankle, Romberg, Babinski, Cranial Nerves, sensory, coordination, tremor, vibratory

**MENTAL STATUS:**
ALOC x 3, affect, judgment, cognition, memory, abstraction, hallucination/delusions

Breasts, Rectal, Gyn and male GU are not required to be examined

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**The physical exam can be no more than 6 months old from date the student will begin classes.**
Name ________________________________

Last First Middle

Other Findings:

____________________________________________________________________________________________________

Please describe any significant emotional problems: _____________________________________________________________

Are there any restrictions on physical activity?  No  Yes  If yes, please explain: ________________________________

____________________________________________________________________________________________________

Are there any recommendations for continued medical care?  No  Yes  If yes, please explain:

____________________________________________________________________________________________________

Date received Tdap (tetanus/diphtheria/acellular pertussis) vaccination: _____________________________

NOTE: A TD and/or Dtap will NOT be accepted

Tuberculosis clearance (student must submit TB clearance from only 1 of the 3 options described below):

1. **TB PPD skin test.** NOTE: A 2-Step TB PPD (the 2nd PPD must be administered at least 10 days from the 1st PPD being administered) is required if the student has not had a PPD in more than 1 year, or 365 days.

   Date 1st PPD Placed: _______________  Date 1st PPD Read: _______________

   Results of 1st PPD: _______________ Millimeters of Induration (the words “negative” or “positive” are unacceptable)

   Date 2nd PPD Placed: _______________  Date 2nd PPD Read: _______________

   Results of 2nd PPD: _______________ Millimeters of Induration (the words “negative” or “positive” are unacceptable)

   Having a history of receiving the BCG vaccine alone is not acceptable as a positive PPD history unless a skin test has been given and the result was 10mm or greater.

2. **IGRA (e.g., Quantiferon or T-spot).** Lab report must not be more than 6 months from the first day of matriculation.

   In addition, student must submit a completed TB Symptoms Health Screening checklist. IGRA Date: _______________

   (Note: This test is valid for 4 years at WesternU).

3. **Chest x-ray/radiology report.** If student has a positive PPD history a current chest x-ray report must not be more than 6 months from the first day of matriculation is required.

   In addition, student must submit a completed TB Symptoms Health Screening checklist. Chest x-ray date: _______________

Healthcare provider name (printed/stamped): ____________________________________________________________

Signature: ___________________________________________  Date: __________________________

Address of Healthcare provider: ________________________________

Phone number (please include country code if outside of USA): ________________________________

Rev 11-16-11; 9-26-12; 1-10-14; 12-4-14; 9-24-15; 9-14-16; 9-14-17
Form D: Immunization/Titer Results

Name: ___________________________  WesternUID# @ __________________

Serum blood titers are NOT the same as vaccinations/immunizations. Copies of all titer lab reports must be submitted.

1. **Hepatitis B Surf Ab, Quantitative QN**
   Titer Date: _____________________  Titer Results: _________________________
   **Note:** If Negative, Start Hepatitis B Series: #1 __________ #2 ________ #3 ________
   **Day 0**  **30 Days After #1**  **6 Months after #1**

   **Only a QUANTITATIVE titer result will be accepted.**

   **NOTE:** If you have received two complete Hepatitis B series’ (one series consists of 3 vaccines) and the titer still shows no immunity, then you must provide proof of two complete vaccination series before you can be declared a Hepatitis B non-converter. Once declared a non-converter, you will not be required to receive any more Hepatitis B vaccines.

   **Hepatitis B Carrier** Known Hepatitis B carriers are required to have the additional blood tests listed below and the results must be included in the health clearance documents you submit:
   Date: _________________  Hepatitis B Surface Ag, Hepatitis B core Ab, and Hepatitis Be Ag

2. **Measles (Rubeola) AB, IgG, EIA**
   Titer Date: _________________  Titer Results: _________________
   **Note:** If titer results are negative or inconclusive/equivocal and you have no documentation showing you have completed the MMR vaccine series (2 vaccines) then you must start the vaccination series which is 2 immunizations 30 days apart.
   Date of Immunization #1: _________________  Date of Immunization #2: _________________

   If your titers are inconclusive and you do have documentation showing you have completed the MMR vaccination series, a booster MMR is recommended.

3. **Mumps Antibodies, IgG**
   Titer Date: _________________  Titer Results: _________________
   **Note:** If titer results are negative or inconclusive/equivocal and you have no documentation showing you have completed the MMR vaccine series (2 vaccines) then you must start the vaccination series which is 2 immunizations 30 days apart.
   Date of Immunization #1: _________________  Date of Immunization #2: _________________

   If your titers are inconclusive and you do have documentation showing you have completed the MMR vaccination series, a booster MMR is recommended.

4. **Rubella Antibodies, IgG**
   Titer Date: _________________  Titer Results: _________________
   **Note:** If titer results are negative or inconclusive/equivocal and you have no documentation showing you have completed the MMR vaccine series (2 vaccines) then you must start the vaccination series which is 2 immunizations 30 days apart.
   Date of Immunization #1: _________________  Date of Immunization #2: _________________

   If your titers are inconclusive and you do have documentation showing you have completed the MMR vaccination series, a booster MMR is recommended.

   **Titers cannot be more than 1 year old**

Rev 11-30-11; 9-26-12; 1-10-14; 12-4-14; 9-24-15; 9-14-16; 9-14-17
5. **Varicella IgG AB**

Titer date: _______________  Titer Results: __________________________

**Note:** If titer results are negative or inconclusive/equivocal and you have no documentation showing you have completed the varicella vaccine series (2 vaccines) then you must start the vaccination series which is 2 immunizations 30 days apart.

   Date of Immunization #1: _______________  Date of Immunization #2: _______________

If your titers are inconclusive and you do have documentation showing you have completed the varicella vaccination series, a booster varicella is recommended.

6. **Tetanus Diphtheria Acellular Pertussis (Tdap) Booster:**

   Tdap Booster date: _______________  NOTE: A Td/Dtap will NOT be accepted.

7. **Immunization Records:** A copy of all of your immunization records (beginning in childhood) must be submitted.

8. **Tuberculosis (TB) Clearance [Submit only 1 of 3 options described below]:** TB clearance is a yearly, mandated requirement.

   **• TB PPD skin test.** **Note:** A 2-Step TB PPD (the 2nd PPD must be administered at least 10 days from the 1st PPD being administered) is required if the student has not had a PPD in more than 1 year, or 365 days.

   Date 1st PPD Placed: __________  Date 1st PPD Read: __________

   Results of 1st PPD: ________ Millimeters of Induration (the words “negative” or “positive” are unacceptable)

   Date 2nd PPD Placed: __________  Date 2nd PPD Read: __________

   Results of 2nd PPD: ________ Millimeters of Induration (the words “negative” or “positive” are unacceptable)

   Having a history of receiving the BCG vaccine alone is not acceptable as a positive PPD history unless a skin test has been given and the result was 10mm or greater.

   **• IGRA (e.g., Quantiferon or T-spot).** Must provide copies of the lab report and it must not be more than 6 months from the first day of matriculation. **In addition, you must submit a completed TB Symptoms Health Screening checklist.** IGRA Date: ______ (Note: This test is valid for 4 years at WesternU).

   **• Chest x-ray/radiology report.** If student has a positive PPD history a current chest x-ray report that is no more than six (6) months from the first day of matriculation is required. **In addition, student must submit a completed TB Symptoms Health Screening checklist.**

   Chest X-ray Date: _______________  *Must provide copy of Radiology report*

___________________________________________________________________________

Healthcare Provider Signature

___________________________________________________________________________

Printed Name of Licensed Healthcare Provider  Date

___________________________________________________________________________

Signature of Licensed Healthcare Provider

___________________________________________________________________________

Address of Healthcare Provider  City  Zip/Province Code Country

Rev 11-16-11; 9-26-12; 1-10-14; 12-4-14; 9-24-15; 9-14-16; 9-14-17; 3-14-18
TB Symptoms Health Screening Checklist

This form only applies to those required to have a chest x-ray or have had an IGRA (Quantiferon) test.

Name: ________________________________ Date: ____________________

Student/Employee ID # ___________________________ Department: ____________________ Grad. Year: 20 _________

College: COMP-CA  COMP-OR  Dental  MSMS  Nursing  Optometry  PT  PA  Pharmacy  Podiatry  Vet Med

Name_________________________ Birth Date_________________________

Address ________________________________ City __________ Zip Code__________

Telephone Number ____________________________

Have you ever had a BCG vaccination? Yes  No  If yes, it is preferred that you obtain an IGRA (e.g., Quantiferon or T-spot test)

Date of last PPD ________________________________ PPD Results __________ MM

Date of IGRA (e.g., Quantiferon/T-Spot) test: __________________________ Results: __________________

Date of Last Chest X-Ray: ____________ Results: ______ Positive for TB ______ Negative for TB

1. Have you ever been told you have active tuberculosis? ( ) Yes ( ) No

2. Have you ever taken Isoniazid (INH) or Rifampin (RIF)? ( ) Yes ( ) No

3. Date and duration of medication regime (months)

4. During the past year have you noticed:
   • Unexplained weight loss? ......................... ( ) Yes ( ) No
   • Decrease in your appetite? ....................... ( ) Yes ( ) No
   • Cough not associated with cold or flu? ...... ( ) Yes ( ) No
   • Increase in AMOUNT of Sputum? ............. ( ) Yes ( ) No
   • Change in COLOR of Sputum? ............... ( ) Yes ( ) No
   • Change in CONSISTENCY of Sputum? ....... ( ) Yes ( ) No
   • Blood Streaked Sputum? ...... ( ) Yes ( ) No
   • Night sweats? ........... ( ) Yes ( ) No
   • Unexplained low grade fever? ...... ( ) Yes ( ) No
   • Unusual tiredness or fatigue? ...... ( ) Yes ( ) No
   • Swelling of lymph nodes? ............ ( ) Yes ( ) No
   • Have you had contact with a family member or partner who has been diagnosed with tuberculosis? ( ) Yes ( ) No
   • Have you or a member of your family been exposed to someone who is immune compromised? ( ) Yes ( ) No

Explain any “Yes” answers above:

List any on-going medical problem ________________________________

Signature of Person Completing this form __________________________ Date ________________

Plan of care, if indicated: ____________________________________________

Signature of Reviewer: __________________________ Date ________________

_______ No further action needed  ________ Chest X-Ray Requested  ________ Further Evaluation Needed

Must be reviewed by licensed healthcare provider if any “yes” answers

TB Symptoms Questionnaire 7-22-10; Rev 4-7-11; 8-12-11; 9-7-11; 6-18-15; 7-20-16
Authorization for Release of Communicable Disease Clearance Information to Clinical Rotation Sites

Date: _____________________________ WesternU ID#: @ _____________________________

I, ________________________________ born on _________________, hereby authorize:
(Student Name)
Western University of Health Sciences
Student Health Office
100 W. Second Street, Room 219
Pomona CA, 91766-1700

To release to the extent permitted by law, the following medical information that Western University of Health Sciences (WesternU) now has in its possession, or that it may create or receive from any third party in the future:
- Immunization information (including titer results)
- Tuberculosis clearance
- History and Physical Exam report

I understand that this information must be provided, if requested, in order to prove to a clinical rotation site that I meet all communicable disease clearance requirements as required by the University. I also understand that if I do not allow this information to be provided to the various clinical rotation sites, a clinical rotation site can refuse to allow me to rotate through its facility. I am also acknowledging that if I cannot complete the clinical rotations required for my degree and/or licensure because of my refusal to authorize the release of my communicable disease clearance information to the clinical rotation sites, I agree to hold the University harmless to the extent permitted by law. I also am aware that this Authorization will remain in effect for the duration of my time as a student at WesternU and will expire on the date of my graduation from the University.

I understand that it is my responsibility to remember to renew my Tuberculosis clearance each year before it will expire. If the PPD skin test does expire, I know I will be required to complete 2 separate PPD skin tests in order to be in compliance with the TB clearance protocol. I understand that if my TB clearance was completed by chest x-ray or serum blood test, I must complete a TB symptoms checklist and submit it to the Student Health Office on a yearly basis.

I understand I must obtain and submit proof of receiving the yearly Influenza vaccination no later than November 30th of each year to the Student Health Office. I am also aware the only exception to this mandatory vaccination requirement is if there is a medical contraindication and that a physician’s note attesting to this fact must be provided to the Student Health Office.

I am aware I will not be notified of a hold placed on my account if my health clearance requirements are not up to date. I also understand the hold will not be removed until I have submitted any outstanding items to the Student Health Office. This means I will not be able to register for classes or obtain financial aid until the hold is cleared.

By signing this Authorization, I agree with all the provisions stated in this Authorization for the release of the specified information and continued health clearance requirements.

Signature of Student _____________________________ Printed Name of Student _____________________________
AUTHORIZATION FOR RELEASE OF STUDENT HEALTH CLEARANCE DOCUMENTS

College: COMP-CA  COMP-OR  Dental  MSMS  Nursing  Optometry  PA  Pharmacy  Podiatry  PT  Vet Med

Student ID # @ __________________________________     Grad Year 20 _____________

Please Print

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Sex: Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>City/State/Zip</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

I hereby request and authorize that the **Student-Employee Health Office** email my Health Clearance Records to my **WesternU email address** of: ______________________@westernu.edu or to ______________________

The Health Clearance Records I am authorizing for release include:

* Immunizations/Titers  * Tuberculosis Clearance Documents  * History and Physical Exam

Other: ________________________________

NOTE: Unless lined out, those with an * will be sent to the email address you indicate

A handwritten signature is required in order to activate this request.

Student Signature ______________________ Date ______________________

Note: A photocopy or electronic scan of this document shall be as valid as an original.

This Authorization is valid until otherwise notified in writing.
Health Clearance FAQs

Immunizations, Tuberculosis Clearance & Titers

Q—Why do I need to submit my immunization records and serum titers?
A—Many clinical rotation sites that our student’s rotate through require copies of both your immunization records and serum titer results. When you are preparing to start at a clinical rotation site that requires this information, you will just need to contact the Student Health Office and the information can be provided immediately instead of days or weeks later (If you are having trouble locating your immunization records, you may want to check with your high school/undergraduate college/university Health Center to see if they have a copy of your vaccination history).

Q—If my healthcare provider writes a note stating the student “is up-to-date on all vaccines,” is this acceptable?
A—No. Documentation requirements for your health records must show the specific dates you received the vaccines. Health records may be in the form of original vaccination records (or a clear copy) or a letter from the healthcare provider on their letterhead or printed prescription (no emails allowed) stating the vaccine name and dates each was administered. The letter must be signed by the healthcare provider. We will not accept school records, family member statements or baby book entries.

Q—If I get behind in a vaccination series (i.e., hepatitis B, MMR or varicella), what should I do?
A—you will pick up where you left off and complete the vaccination series. For example, you received 2 of the 3 vaccinations for hepatitis B but you have not received the 3rd dose of the vaccine. If it has been less than 5 years since you started the series, then you can go ahead and just receive the final dose. If more than 5 years have lapsed, it is recommended that with some vaccines you start the entire series over. Your healthcare provider can help evaluate what you should do. If you can show you have started a vaccine series, you will be allowed to register for your first semester but until you provide proof you have completed the series, you will not be allowed to register for any subsequent semesters/classes.

Q—If I received a vaccine dose earlier than the minimum interval recommended, is this acceptable?
A—No it is not. The dose of vaccine is invalid and must be re-administered after the minimum interval has been met. For example, the hepatitis B minimum intervals are as follows: Dose 1 is administered. Dose 2 should be separated from dose 1 by at least one month (4 weeks or 28 days). Dose 3 should be separated from dose 2 by at least 2 months (8 weeks) AND from dose 1 by at least 4 months (16 weeks).

Q—Will vaccines interfere with my TB skin test (commonly known as a PPD) results?
A—Some vaccines may. For example, the MMR vaccine may interfere with PPD results (may have a false negative result in someone who actually has an infection with TB) if the vaccine is administered within 4-weeks of the PPD. However, the MMR vaccine can be administered at the same time and on the same day as the PPD. The hepatitis B, tetanus and rabies vaccines can be administered any time without interfering with PPD results.

Q—How do I know if my 1st PPD will be accepted or counted?
A—if you have not had a PPD in more than one year, you are required to complete the 2-Step PPD process before your complete TB clearance requirement has been met. The 2nd PPD must be administered at least 10-days from the 1st PPD being administered.

Q—If I received the TB skin test at WesternU, can I have a healthcare provider at a non-WesternU clinical rotation site read the TB skin test results and document them?
A—if your clinical site is near a WesternU campus, then the answer is no. It must be read at WesternU and documentation must then be provided to the Student Health Office located on the Pomona campus. However, if your clinical rotation site is not near the campus, you can have the TB skin test read by the Employee/Occupational Health nurse at the clinical facility you are rotating through. The results can be faxed to 909-706-3785 or scanned and emailed to stu-emphealth@westernu.edu.

Q—Can I submit an IGRA (e.g., Quantiferon or T-spot) blood test for TB clearance?
A—Yes. The test cannot be more than 6 months from your first day of matriculation. This test is valid at the university for 4 years. However, you are still required to submit a completed TB Symptoms Health Screening form on a yearly basis.

Q—Do I only have to complete a TB clearance on a yearly basis?
A—not necessarily. Some clinical rotations sites have more stringent TB clearance requirements that you must comply with in order for you to be permitted to go to that site.

Q—Do I need to get a PPD if I have a history of a positive PPD?
A—No. You are required to obtain a chest x-ray (x-ray cannot be more than 6 months old from the time of your submitting your health clearance forms) and complete the TB symptoms checklist included in this packet. We do not need the actual chest x-ray film; we only need the radiologist’s written report.
Q—I am healthy. Why should I be required to show that I have been immunized?
A—As members of the WesternU community, it is very important for all of us to be free from communicable diseases that can threaten those around us. Many of these diseases are preventable with appropriate vaccination. Also, in order for you to participate in your required clinical rotations, you must be able to show proof that you are not at risk for contracting a vaccine preventable communicable disease.

Q—If I received my second Hepatitis B vaccine later than recommended after the first vaccine, how soon after getting the second Hepatitis B vaccine can I receive the third and final Hepatitis B vaccine?
A—If you had the 2nd vaccine several months after the first one, you can receive your 3rd and final Hepatitis B vaccine 60-days after the 2nd vaccine. A serum blood titer is still required 30-days after vaccine number three.

Q—If I have completed 2 full Hepatitis B series (1 series consists of 3 vaccines) and my titer is still showing I do not have immunity, do I need to receive another series?
A—No, because most likely you are a non-converter, however, you will need to provide us with the documentation showing that you have completed 2 entire Hepatitis B vaccination series and a current Hepatitis B Surface Ab, QN titer.

Titters

Q—What titters should I ask my physician/healthcare provider to order?
A—Hepatitis B, Surf AB QN; Measles AB IgG, EIA; Rubella Antibodies, IgG; Mumps Antibodies, IgG; Varicella IgG AB. NOTE: the Hepatitis B titer results MUST be Quantitative and include the references ranges or we will not accept the test results.

Q—What should I do if the blood titers show I am not immune to the vaccine preventable disease(s)?
A—Unless you have a documented medical condition that contraindicates the administration of the vaccine(s), you may be required to be vaccinated/revaccinated for those diseases that you have no immunity against.

Q—When is a rabies titer needed?
If you are a veterinary medicine student who has already completed the rabies vaccination series more than 2 years ago (3 vaccines), you are required to have a rabies titer and submit the titer results along with the dates you received each of the rabies vaccine. In accordance with the Centers for Disease Control and Prevention (CDC), the recommended serum blood test for rabies is called rapid fluorescent focus inhibition test (RFFIT). No other rabies testing results will be accepted. (CDC Rabies information: http://cdc.gov/rabies/specific_groups/doctors/serology.html)

General Questions

Q—What would happen to me if I don’t complete the health clearance requirements?
A—Every incoming student, whether new to WesternU, repeating or returning from a leave of absence, is required to comply with all health clearance requirements. If you do not complete these requirements, a registration hold will be placed, or in extreme cases, your acceptance to attend WesternU may be rescinded.

Q—I am going to be returning to WesternU after being on a leave of absence for more than 6 months. Do I have to do the entire health clearance process?
A—If you have already submitted serum titers (as described/required in the health clearance packet) and immunizations records, then all you will need to submit is an updated medical history, physical exam, and TB clearance.

Q—If my healthcare provider writes a note stating I have had a communicable disease, is this acceptable?
A—No. Documentation of select communicable diseases that were “physician diagnosed” and not confirmed through blood tests, are no longer accepted as evidence of immunity. Because of this, the required vaccine preventable diseases that have blood tests to determine if immunity exists or not (referred to as titers), are required for hepatitis B, measles, mumps, rubella, and varicella.

Q—If I have had the Hepatitis B disease and my physician states I do not need to have the Hepatitis B vaccination series, what should I ask my physician to include in the health records and documents sent back to Western University?
A—Have your physician provide the lab test results that confirm a prior Hepatitis B diagnosis (see form D for the additional required serum titers) and include a note about the status of your Hepatitis B disease [for example, “continue to monitor viral loads every 6 months”] on the History and Physical examination form your physician completes. (This would also apply to those persons who have a “native immunity” to Hepatitis B.)
Q—What if I have a health condition that is a contraindication to receiving a particular vaccination?
A—A letter from your healthcare provider attesting to this contraindication will be acceptable. However, if your current health status is such that a particular immunization is temporarily contraindicated, you will still be responsible for obtaining that immunization as soon as your health issue has resolved and prior to starting any clinical rotation.

Q—What if my religious beliefs do not allow me to be immunized?
A—There are no religious exemption from the University immunization requirements. One should explore with his/her healthcare provider for the availability of vaccine formulations that do not involve the use of blood or select animal products, or document immunity as a result of prior infection. The University’s commitment to minimize the potential harm to you and any patients or colleagues that you may encounter in your future career is of paramount concern to the university. Only a legitimate medical contraindication to vaccination will exempt a student from the University’s immunization requirements.

Q—Can I participate in clinical rotations if I am still updating/completing the required vaccines and TB clearance?
A—in order for you to be able to start your clinical rotations you must have had at least 2 doses of Hepatitis B vaccine, completed the MMR and varicella series, have a current Tdap vaccine, as well as have a current TB clearance and the current influenza vaccination. You must provide proof that you have completed all of the communicable disease clearance requirements or you will be removed from clinical rotations; will not be allowed to register for the next semester; and if you receive financial aid, you will not receive your funds until these requirements have been fulfilled.

Q—If I am pregnant can I be vaccinated safely?
A—Some vaccines can be administered safely during pregnancy. However, it is recommended that you consult with your obstetrician prior to receiving any vaccines.

Q—If I am pregnant, can I participate in my clinical rotations without having completed the required vaccinations?
A—A pregnant student can receive a temporary medical exemption and still participate in some clinical rotations. However, it is strongly recommended that you work closely with your faculty advisor to determine if it is permitted by the clinical site you would be going to as well as your obstetrician.

Q—How long will it take to process my health clearance forms?
A—you will need to allow at least 5 business days from the date we receive all of your required health clearance forms. If you have not received a confirmation email from the Student Health Office by the end of the 5th business day, you should contact us. Note: all forms are processed on a first come, first served basis.

Q—When is the deadline for submission of all my health clearance forms/documents?
A—Please refer to your college’s catalogue or acceptance letter you received for this information.
Most Health Insurance Plans are accepted. Physical exam fees are dependent upon medical needs as determined by the health care provider. A 20% discount is offered should you pay for the entire visit at the time of service.

### Immunizations

<table>
<thead>
<tr>
<th>Immunizations</th>
<th>Cost per Vaccine from PCC Pharmacy</th>
<th>Chest X-ray: $57.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td>$90.00</td>
<td>Pomona Valley Hospital Medical Center, Department of Radiology has a location on the 2nd Floor of PCC in Pomona</td>
</tr>
<tr>
<td>Influenza</td>
<td>$30.00</td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td>$98.00</td>
<td>NOTE: For cash/credit card payments no radiology reading fee.</td>
</tr>
<tr>
<td>PPD-TB skin test</td>
<td>$25.00</td>
<td>If billed to insurance there is a radiology reading fee for a total of $740.00 that you will be responsible for ensuring it has been paid.</td>
</tr>
<tr>
<td>Tdap</td>
<td>$69.00</td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>$132.00</td>
<td></td>
</tr>
</tbody>
</table>

### Veterinary Students Only

Rabies Vaccine $363.00 per vaccine if received at the WesternU Patient Care Center Pharmacy (price subject to change without notice)

Charges for serum titers if the blood is collected at the PCC Medical Center in Pomona.

<table>
<thead>
<tr>
<th>Titers</th>
<th>Cost if sent to Lab Corp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B Sur AB QN</td>
<td>$75.25</td>
</tr>
<tr>
<td>Rubeola AB IgG, EIA</td>
<td>$26.75</td>
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<tr>
<td>Rubella Antibodies, IgG</td>
<td>$13.25</td>
</tr>
<tr>
<td>Mumps Antibodies, IgG</td>
<td>$23.00</td>
</tr>
<tr>
<td>Varicella IgG AB</td>
<td>$26.00</td>
</tr>
</tbody>
</table>

NOTE: If you chose to have your labs drawn at a facility other than the PCC, and you do not want to go to your healthcare provider’s office, you must obtain the lab order from the Student Health Office BEFORE going to an outside lab for your blood draw.

There will be a fee of $10.00 charged for the phlebotomy (blood draw process)

* Fees accurate as of 3-14-2018

Please note all prices listed may change without any notice. For current pricing, contact the center at the numbers listed above.