

SABA UNIVERSITY SCHOOL OF MEDICINE

Clinical Department
27 Jackson Rd., Suite 301
Devens, MA 01434



Please return this form to:
Phone: 978-862-9600
Email: annualcompliance@saba.edu

STUDENT HEALTH RECORD

STUDENT IMMUNIZATION, PHYSICAL EXAM and MEDICATION FORM to be complete by matriculation

Student Name: _____ Date of Birth _____
Last First MM/DD/YY

Address: _____ Telephone: _____

Student ID# _____ School Email: _____

Immunization Status *(TITER LAB REPORT MUST BE ATTACHED)*

IgG Quantitative Titer	Date	Result	
Rubella (German Measles)	_____	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative <input type="checkbox"/> Valid Proof of Immunization Attached
Rubeola (Measles)	_____	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative <input type="checkbox"/> Valid Proof of Immunization Attached
Mumps	_____	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative <input type="checkbox"/> Valid Proof of Immunization Attached
Varicella	_____	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative <input type="checkbox"/> Valid Proof of Immunization Attached

Hepatitis B Vaccination – 3 doses of vaccine followed by a **QUANTITATIVE** Hepatitis B Surface Antibody (titer) preferably drawn 4-8 weeks after 3rd dose. If negative, complete a second Hepatitis B series followed by a repeat titer. If Hepatitis B Surface Antibody is negative after secondary series, additional testing including Hepatitis B Surface Antigen should be performed. See: <http://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf> for more information.
 Documentation of Chronic Active Hepatitis B is for rotation assignments and counseling purposes only.

	Date	
Primary Hepatitis B Series	Hepatitis B Vaccine Dose #1	Attach Valid Proof of Immunization
	Hepatitis B Vaccine Dose #2	
	Hepatitis B Vaccine Dose #3	
	QUANTITATIVE Hep B Surface Antibody	Result mlU/ml
Secondary Hepatitis B Series <small>(if no response to primary series)</small>	Hepatitis B Vaccine Dose #4	Attach Valid Proof of Immunization
	Hepatitis B Vaccine Dose #5	
	Hepatitis B Vaccine Dose #6	
	QUANTITATIVE Hep B Surface Antibody	Result mlU/ml
Hepatitis B Vaccine Non-responder <small>(If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)</small>	Hepatitis B Surface Antigen (if 2 nd titer negative)	Attach Document
	Hepatitis B Core Antibody (if 2 nd titer negative)	Attach Document
Chronic Active Hepatitis B <small>(specialist evaluation required)</small>	Hepatitis B Surface Antigen	Attach Document
	Hepatitis B Viral Load	Attach Document

Tetanus-diphtheria-pertussis – One (1) dose of **adult** Tdap. If last Tdap is more than 10 years old, provide date of Td and Tdap

	Date	
Tdap Vaccine (Adacel, Boostrix, etc)	_____	Attach Valid Proof of Immunization
Td Vaccine <small>(if more than 10 years since last Tdap)</small>	_____	Attach Valid Proof of Immunization

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COVID-19 IMMUNIZATION Submit pdf of vaccine card showing full immunization (2 dose Pfizer/Moderna or 1 dose J&J)
Note: booster dose will be required when approved and timing determined

	Date	
COVID-19 Vaccine, Dose 1	_____	Attach Document
COVID-19 Vaccine, Dose 2	_____	Attach Document
<i>Booster/Immunocompromised</i> COVID-19 Vaccine, Dose 3	_____	Attach Document

TUBERCULOSIS SCREENING Results of most recent 2-step PPD or IGRA blood test are required regardless of prior BCG status. If you have a history of a positive TST (PPD) ≥ 10 mm or IGRA please supply information regarding any evaluation and/or treatment below. You only need to complete ONE section.

Note: Annual 1-step PPDs are acceptable only for students with prior documented 2-step PPD

Skin test or IGRA results MUST not expire during proposed rotation dates

Tuberculin Screening History – COMPLETE ONE SECTION ONLY

Please complete one TB section only	Section A	Date Placed	Date Read	Reading	Interpretation	Clinician Signature & Date**	
	Negative Skin or Blood Test History	TST #1	_____	_____	mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	
		TST #2	_____	_____	mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	
		TST #3	_____	_____	mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	
			Date	Result	**or attach document with same		
	Last two skin test or IGRAs required Use additional rows as needed	IGRA Blood Test (Interferon gamma releasing assay)	_____	_____	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	Attach Document	
		IGRA Blood Test (Interferon gamma releasing assay)	_____	_____	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	Attach Document	
		IGRA Blood Test (Interferon gamma releasing assay)	_____	_____	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	Attach Document	
	Section B	Date Placed	Date Read	Reading	Interpretation		
	History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test	Positive TST	_____	_____	mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	Attach Document
				Date	Result		
		Positive IGRA Blood Test	_____	_____	IU	Attach Document	
		Chest X-ray	_____	_____		Attach Document	
		Prophylactic Medications for latent TB taken?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Total duration of prophylaxis?				Months	
TB/ID Specialist evaluation required				Attach Document			
Section C				Date			
History of Active Tuberculosis	Date of Diagnosis			_____			
	Date of Treatment Complete			_____	Attach Document		
	TB/ID Specialist evaluation required			_____	Attach Document		
	Date of Last Chest X-ray			_____	Attach Document		

Influenza Vaccine -1 dose annually each Fall (October 1-March 31)

	Date	
Flu Vaccine	_____	Attach Document*
Flu Vaccine	_____	Attach Document*

*1) Proof of administration of flu vaccine, 2) Lot #of vaccine and 3) Expiration date of vaccine

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****Please note: two pages require physician signature****

PRESCRIBED MEDICATION

Is the student presently taking any form of medication prescribed by a physician? No Yes

If yes, please list the medications and prescriber:

NOTE: This information is relayed to student clerkship sites.

ADDITIONAL INFORMATION

Signature of Physician

Print Name

Address

Date

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PHYSICAL EXAMINATION

I have performed and recorded a clinical evaluation of the above named student which does not reveal any health impairment which may be of potential risk to patients, or which might interfere with the performance of his/her duties, or indicates substance abuse or dependence.

ADDITIONAL INFORMATION

NOTE: This information is relayed to student clerkship sites.

Signature of Physician

Print Name

Address

Date