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 Titer	**Date**	**Result**	
Rubella (German Measles)	_____	☐ Positive	☐ Negative ☐ Valid Proof of Immunization Attached
Rubeola (Measles)	_____	☐ Positive	☐ Negative ☐ Valid Proof of Immunization Attached
Mumps	_____	☐ Positive	☐ Negative ☐ Valid Proof of Immunization Attached
Varicella	_____	☐ Positive	☐ Negative ☐ Valid Proof of Immunization Attached

Hepatitis B Vaccination – *3 doses of vaccine followed by a 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	_____		
	Hep B Surface Antibody	_____	**Result** mlU/ml	Attach Document
Secondary Hepatitis B Series *(if no response to primary series)*	Hepatitis B Vaccine Dose #4	_____	Attach Valid Proof of Immunization	
	Hepatitis B Vaccine Dose #5	_____		
	Hepatitis B Vaccine Dose #6	_____		
	Hep B Surface Antibody	_____	**Result** mlU/ml	Attach Document
Hepatitis B Vaccine Non-responder *(If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)*	Hepatitis B Surface Antigen (if 2nd titer negative)	_____	Attach Document	
	Hepatitis B Core Antibody (if 2nd titer negative)	_____	Attach Document	
Chronic Active Hepatitis B (specialist evaluation required)	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 *(if more than 10 years since last Tdap)*	_____	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
Booster/Immunocompromised	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) ≥10mm 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

Please complete one TB section only

Tuberculin Screening History – COMPLETE ONE SECTION ONLY

Section A		**Date Placed**	**Date Read**	**Reading**	**Interpretation**	**Clinician Signature & Date****
Negative Skin or Blood Test History	TST #1			mm	☐Pos ☐Neg ☐Equiv	
	TST #2			mm	☐Pos ☐Neg ☐Equiv	
	TST #3			mm	☐Pos ☐Neg ☐Equiv	
			Date	**Result**	**or attach document with same	
Last two skin test or IGRAs required	IGRA Blood Test (Interferon gamma releasing assay)			☐ Negative ☐ Indeterminate	Attach Document	
Use additional rows as needed	IGRA Blood Test (Interferon gamma releasing assay)			☐ Negative ☐ Indeterminate	Attach Document	
	IGRA Blood Test (Interferon gamma releasing assay)			☐ Negative ☐ 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	☐ Pos ☐Neg ☐Eqiv	Attach Document
			Date	**Result**		
	Positive IGRA Blood Test			IU	Attach Document	
	Chest X-ray				Attach Document	
	Prophylactic Medications for latent TB taken?				☐ Yes ☐ 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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Last	*First*	*MM /DD/ YY*	

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**