

**UNIVERSITY OF MARYLAND, BALTIMORE**  
**Student Health Clearance/Verification**

**NAME** \_\_\_\_\_

Date of Birth:     /     /

School:

**IMMUNIZATIONS** (Note: MMR dates must include month/day/year.)

**Diphtheria/Tetanus**

Date:     /     /

Date:     /     /

**Measles**

(if applicable)

Date:     /     /

Titer:     /     /

Immune

Nonimmune

Date:     /     /

Disease:   /     /

**Mumps**

(if applicable)

Date:     /     /

Titer:     /     /

Immune

Nonimmune

Date:     /     /

Disease:   /     /

**Rubella**

(if applicable)

Date:     /     /

Titer:     /     /

Immune

Nonimmune

Date:     /     /

Disease:   /     /

**Varicella**

(if applicable)

Date:     /     /

Titer:     /     /

Immune

Nonimmune

Date:     /     /

Disease:   /     /

**Hepatitis B**

(if applicable)

Date:     /     /

Titer:     /     /

Immune

Nonimmune

Date:     /     /

Titer:     /     /

Immune

Nonimmune

Date:     /     /

**Tuberculosis**

PPD Skin Testing (Within 12 months of rotation)

Date:     /     /

Negative

Positive

\_\_\_\_\_mm

Date:     /     /

Negative

Positive

\_\_\_\_\_mm

Date:     /     /

Negative

Positive

\_\_\_\_\_mm

Date:     /     /

Negative

Positive

\_\_\_\_\_mm

Chest X-ray

Date:     /     /

Negative

Positive

(for PPD positive):

INH treatment \_\_\_\_\_

(CXR report required)

\_(Written report of treatment required)

Verification Signature

Print Name & Telephone Number

Date

**This form must be signed by a physician, registered nurse or public health official.**