



INCOMING STUDENT HEALTH REQUIREMENTS

Academic Year 2005-2006

*University of California, Irvine
Student Health Center
Information (949)824-5301
Appointment (949)824-5304
www.shs.uci.edu*

ALL INCOMING STUDENTS MUST FILE THE FOLLOWING WITH UCI-STUDENT HEALTH CENTER (SHC):

- 1) A HEALTH HISTORY - SEE CONFIDENTIAL PERSONAL HEALTH HISTORY FORM
- 2) PROOF OF MANDATORY IMMUNIZATIONS OR IMMUNITY
- 3) TUBERCULOSIS SCREENING IF INDICATED

THIS FORM IS TO BE COMPLETED LEGIBLY IN ENGLISH BY A LICENSED MEDICAL PROFESSIONAL UNRELATED TO THE STUDENT. RETURN ALL COMPLETED HEALTH DOCUMENTS TO THE STUDENT HEALTH CENTER PRIOR TO COMMENCEMENT OF THE QUARTER OF THE STUDENT'S ENTRY TO UCI.

FAILURE TO COMPLY MAY RESULT IN A HOLD BEING PLACED ON THE STUDENT'S REGISTRATION.

Last	First	M.I.			
Name _____			Gender _____	Date of Birth _____	
Address _____			Age at Enrollment _____		
Phone No. _____		Emergency Phone No. _____			
Year/Quarter Entering UCI _____		Undergraduate <input type="checkbox"/>	Other: _____		

PART I. MANDATORY IMMUNIZATIONS OR PROOF OF IMMUNITY FOR ALL STUDENTS:

Attach copy of immunization records if available (foreign records must be translated into English).

A. Measles-Mumps-Rubella (MMR) vaccine **Month/Year**

Two (2) doses are required for students born after 1956:

Dose #1 given at 12 months after birth or later ____/____

Dose #2 must be at least one month after dose #1 and after 1980 ____/____

OR proof of positive immune titers (attach copy of lab report) ____/____

B. Hepatitis B Vaccine MANDATED by the State of California for all students age 18 or younger as of the first day of the first quarter enrolled*

*Required if the student has not yet turned 19 years old on the first day of the applicable academic quarter:
 Fall 2005: September 19, 2005 Winter 2006: January 4, 2006 Spring 2006: March 29, 2006

Check below:

- Hepatitis B vaccine 3-dose program initiated or completed.
 Vaccine Dates: Dose #1 _____ #2 _____ #3 _____
- Student has known immunity against the Hepatitis B virus by prior infection or by known immune antibody titer. Must attach lab report.
 Hepatitis B surface antibody titer _____ Date _____
- Student is a known chronic carrier of HBV therefore vaccine is not indicated.
- N/A. Student will be 19 years old or older on the first day of the first quarter enrolled at UCI.

Name _____
Last First MI

PART II. TUBERCULOSIS (TB) SCREENING - MANDATORY FOR STUDENTS AT HIGHER RISK FOR TB

The **American College Health Association** recommends and UCI mandates tuberculosis screening for those incoming students who have arrived in the United States within the last 5 years from any foreign country **except** the following:

- American region: Canada, Jamaica, Saint Lucia, Saint Kitts and Nevis, U.S. Virgin Islands
- European region: Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom
- Western Pacific region: American Samoa, Australia, New Zealand

Student at higher risk as defined above, OR having traveled to a TB-prevalent country within the previous 6 months:

PPD (purified protein derivative) Mantoux skin test within 6 months prior to entry to UCI is required regardless of previous BCG vaccination. Result of PPD must be clearly stated.

- Date of PPD _____ Negative Positive Induration size _____ mm
- Chest x-ray is required if induration is 10 mm or greater. Date _____ Result _____
- If PPD had been positive in the past, a chest x-ray can be done in lieu of a PPD but must be taken within 6 months prior to entry to UCI. Date of chest x-ray _____ Result _____
- History of INH (isoniazid) treatment? No Yes Date completed _____

Student not at high risk; TB screening not required.

PART III. MENINGOCOCCAL VACCINE (Recommended but not mandatory)

This vaccine is optional for admission to UCI, but is strongly recommended for students who will be residing in dormitories or residence halls.

Date vaccine given: _____

PART IV. ADDITIONAL REQUIREMENTS FOR INTERNATIONAL STUDENTS ONLY:

Month/Year

A. **Polio vaccine primary series** of four must be completed. Series completed in: ____/____

B. **Tetanus-Diphtheria (Td) vaccine booster** within the last ten (10) years: ____/____

C. **TB skin test** ___ or **chest x-ray** ___ (check one) within the previous 6 months: Result: ____ ____/____

Form Completed By:

Printed Name _____ Medical Professional Title _____

Signature _____ Date _____ License # _____

Address _____ Phone No. _____

Please return all completed health documents to: Student Health Center, University of California-Irvine, 501 Student Health, Irvine, CA 92697-5200. ATTN: Medical Records