



Office of the Registrar
 College of Medicine
 University of South Florida
 Phone: (813) 974-4089

12901 Bruce B. Downs Blvd MDC 32
 Tampa, FL 33612
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Communicable Disease Prevention Certification: Visiting Medical Students

Applications will not be processed without this completed form. Patient contact will not be permitted until the form and documentation are complete. **All documentation must be in English.**

PRINTED NAME: _____ DATE: _____

STREET: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER(S): _____ EMAIL: _____

DATE OF BIRTH: ___/___/___ Date of physical exam completed for entrance to MD school _____

COMPLETE ITEMS A-H

A. TUBERCULOSIS: Documentation of an initial "2-Step" Tuberculin Skin Test (TST/PPD). The 2nd Test must be at least 1 week and no longer than 12 months from the initial testing. A current "Negative" TST within **6 months** of visit to USF is also required. This current test result can serve as the 2nd Step if administered within 12 months of the previous test date (See MEMO).

TST Step 1	Date	Result	TST Step 2	Date	Result
		___mm induration			___mm induration

If 2nd step of 2-step Tuberculin Skin Test is not within 6 months of start date at USF, you will need to have another TST done and complete the following:

TST	Date (Must be within 6 months of start date)	Result
		___mm induration

Individuals with a history of a positive TST/PPD skin test must submit documentation of a negative chest x-ray within **12 months** of visit to USF **and** a current Screening Questionnaire for signs/symptoms of TB (see memo)*

CXR (if required)	Date:	Result (ATTACHED):
* Current Screening Questionnaire (if required)		Date ___/___/___
History of INH for treatment of Latent TB Infection: From ___/___/___ To ___/___/___		Required Documentation Completed Questionnaire Copy
Received BCG vaccine Yes <input type="checkbox"/> No <input type="checkbox"/>		

B. RUBELLA (German Measles): Serologic documentation of a positive Rubella immune titer **OR** immunization with at least **one dose of live Rubella or MMR vaccine after 12 months of age.**

	Result	Date	Required Documentation
Rubella Titer (IgG Blood Test)	Pos <input type="checkbox"/> Neg <input type="checkbox"/>	___/___/___	Lab Report Copy
Or One live Rubella or MMR vaccine after 1/1/80	#1	___/___/___	Vaccine Documentation Copy

C. RUBEOLA: (10 Day Measles): Serologic documentation of a positive Rubeola immune titer **OR** immunization with **two doses of live Rubeola or MMR vaccine administered after 12 months of age and separated by 28 days or more.**

	Result	Date	Required Documentation
Rubeola Titer (IgG Blood Test)	Pos <input type="checkbox"/> Neg <input type="checkbox"/>	___/___/___	Lab Report Copy
Or Two live Rubeola or Two MMR vaccines after 1/1/80	#1 ___/___/___ #2 ___/___/___		Vaccine Documentation Copy

D. MUMPS: Serologic documentation of a positive Mumps immune titer **OR** immunization with at least **two doses of live Mumps or MMR vaccine after 12 month of age.**

	Result	Date	Required Documentation
Mumps Titer (IgG Blood Test)	Pos <input type="checkbox"/> Neg <input type="checkbox"/>	___/___/___	Lab Report Copy
Or Two live Mumps or Two MMR vaccines after 1/1/80	#1 ___/___/___ #2 ___/___/___		Vaccine Documentation Copy

E. VARICELLA (Chicken Pox): Serologic documentation of a positive Varicella titer **OR** two Varicella immunizations (given 4 to 8 weeks apart). This requirement is satisfied only by a positive titer or the vaccine series.

**** A history of chicken pox does NOT satisfy this requirement ****

	Result	Date	Required Documentation
Varicella Titer (IgG Blood Test)	Pos <input type="checkbox"/> Neg <input type="checkbox"/>	___/___/___	Lab Report Copy
Or Varicella vaccine series	#1 ___/___/___ #2 ___/___/___		Vaccine Documentation Copy



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**Communicable Disease Prevention Certification:
 Medical and Physical Therapy Students (page 2)**

F. Adacel™ or BOOSTRIX® Vaccine Booster: Documentation of an Adult TETANUS/diphtheria/acellular pertussis (Tdap) vaccine booster is required. Tdap was licensed in June, 2005 for use as a single dose booster vaccination (*ie. not for subsequent booster doses*). The current CDC recommendation states "Healthcare personnel, regardless of age, should receive a single dose of Tdap as soon as feasible if they have not previously received Tdap and regardless of the time since last Td dose". After receiving Tdap, personnel should receive routine booster shots against tetanus and diphtheria by existing guidelines (every 10 years).

	<u>Date</u> __/__/__	<u>Required Documentation</u> Vaccine Documentation Copy
Tdap (Adacel™ or BOOSTRIX®) vaccine		

G. HEPATITIS B: Serologic documentation of a Positive (**QUANTITATIVE**) Hepatitis B surface antibody titer following completion of the Hepatitis B vaccination series of 3 injections. You must provide documentation of the Vaccine series **AND** the Positive Antibody Titer to meet this requirement.

	<u>Result</u> Pos <input type="checkbox"/> Neg <input type="checkbox"/>	<u>Date</u> __/__/__	<u>Required Documentation</u> Lab Report Copy
Hepatitis B Surface Antibody Titer (IgG) (Quantitative)			
AND Hepatitis B vaccine series	#1 __/__/__ #2 __/__/__ #3 __/__/__		Vaccine Documentation Copy

H. MENINGITIS: Documentation of immunization with **one dose** of Meningitis vaccine **OR** a completed and signed USF Student Health Services Immunization Health History Form (Block B #4, checkbox, signature) declining receipt of the Meningitis vaccine. The form is available at <http://www.shs.usf.edu/userfiles/files/Medical%20History%20Immunization%20Compliance.pdf> (**Note: Vaccination required only if living in USF Housing.)

	<u>Date:</u> __/__/__	<u>Required Documentation</u> Vaccine Documentation Copy
Meningitis vaccine (**Required if living in USF Housing)		
Or Completed and signed USF SHS Immunization Health History Form (Block B #4, checkbox and signature)		USF SHS Immunization Health History Form

**** Annual Tuberculin Skin Testing (TST) will be required during your entire program. Individuals with negative skin tests on admission will be offered the annual TST at no cost through the Medical Health Administration office or from our clinical affiliates. Individuals with a history of a positive skin test must complete a screening questionnaire annually in lieu of the skin testing.**

**** Influenza Vaccination will be required each year. This vaccine will be provided for you at no cost beginning in October of each year through the USF Medical Clinic/Medical Health Administration office or from our clinical affiliates.**

Note: Several affiliated hospitals require drug and alcohol screening with and without advanced notice.

I. HEALTH CARE PROVIDER CERTIFICATION AND ADDRESS:

I certify that the information noted in items A-H is true and accurate to the best of my knowledge.

SIGNATURE: _____ DATE: _____

Please print/type Health Care or Student Health Provider's name, stamp address, and business phone.



TUBERCULOSIS SCREENING

History of Positive TB Skin Test

Employee/Student Health and Wellness
Division of Infectious Disease and International Medicine
College of Medicine
813-974-3163

Please complete the following information if you have a History of a Positive TB skin test:

EMPLOYEE / STUDENT / FACULTY INFORMATION: **DATE:** _____

Last Name: _____ *Please print!* **First Name:** _____ *Please print!*

College/School: Medicine Public Health Medical Clinics
 Nursing Physical Therapy Other: _____

Department/Unit/Zone: _____

Cell Phone: _____ **Home Phone:** _____

Work Phone: _____ **Mail Code:** _____ **Fax:** _____

Email Address: _____

Position: MD DO ARNP PA Resident / Fellow: PGY ____
 RN LPN MA Student Other: _____

Have you ever received BCG? No Yes → If YES, date of BCG: _____

Date of last PPD skin test: _____

Did you take any medication associated with the positive TB skin test? No Yes → Dates: _____
 What medication(s) did you take? _____

Please check (√) your response for any of the following **unexplained symptoms**:

1. Unexplained fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Unexplained weight loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Loss of appetite	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Fever (usually at night)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Night sweats (drenching)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Persistent cough (>2 weeks)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Spitting/coughing up blood	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Pain in chest	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Date of last chest x-ray: _____ **Results:** _____