PRE-ENTRANCE HEALTH REQUIREMENTS

This form must be COMPLETED in its entirety. (Populate fillable fields or please print clearly)
Documentation is **REQUIRED FOR ALL PROGRAMS and** must be accompanied by a valid, legal immunization record.
Submit the COMPLETED form and required documentation to Student Health Service. Either MAIL at the address below or E-MAIL to studenthealth@llu.edu or FAX to (909) 558-0433 a minimum of three weeks prior to the beginning of registration.

Name: _____ _____ _____ Gender: _____
Last First Middle M / F

Birth Date: _____ / _____ / _____ SS# _____ Student ID# _____ Phone #: (_____) _____
MM DD YY

Starting Program / Classes: _____ / _____
Year Quarter

Check which school you are attending and if requested, specify your program:
☐ Medicine ☐ Pharmacy ☐ Behavioral Health ☐ Allied Health -- specify program: _____
☐ Nursing ☐ Public Health ☐ Religion ☐ Dentistry ☐ Other: _____

REQUIREMENTS	DATE RECEIVED	*FOR OFFICE USE ONLY*
MMR (Measles, Mumps, Rubella) □ **Submit** documentation of 2 MMR vaccinations given after age 1. ----------**OR**---------- **MMR Titer is REQUIRED for the School of Medicine** □ **Submit** positive blood titer reports for each disease. **Must be quantitative (need numerical results) IgG Antibody titers.**	**Immunization #1:** (mm/dd/yyyy) _____ **Immunization #2:** (mm/dd/yyyy) _____ **Date of Titer** (mm/dd/yyyy) Measles _____ Mumps _____ Rubella _____	
Tdap (Tetanus, Diphtheria, Pertussis) □ Documentation of **Tdap** in the last 10 years. ----------**OR**---------- □ **Td** in the last 10 years **AND** One dose of Tdap after age 18.	Date of most recent **Tdap**: (mm/dd/yyyy) _____ Date of most recent **Td**: (mm/dd/yyyy) _____	
HEPATITIS B □ **Submit** documentation of complete series (3 immunizations required) ----------**OR**---------- **Hepatitis B Titer is REQUIRED for the School of Medicine** □ **Submit** positive blood titer report (following vaccine series). **Must be quantitative (need numerical results) Hepatitis B Surface Antibody titer.**	**Immunization #1:** (mm/dd/yyyy) _____ **Immunization #2:** (mm/dd/yyyy) _____ **Immunization #3:** (mm/dd/yyyy) _____ **Date of Titer:** (mm/dd/yyyy) _____	
VARICELLA (Chickenpox) □ **Submit** documentation of 2 Varicella vaccinations given after age 1. ----------**OR**---------- **Please note:** History of disease does not fulfill this requirement **Varicella Titer is REQUIRED for the School of Medicine** □ **Submit** positive blood titer report. **Must be quantitative (need numerical results) IgG Antibody titer**.	**Immunization #1:** (mm/dd/yyyy) _____ **Immunization #2:** (mm/dd/yyyy) _____ **Date of Titer:** (mm/dd/yyyy) _____	
TUBERCULOSIS SCREENING (current within 6 months of program/ class start) □ TB/PPD SKIN TEST **OR** □ BLOOD TEST (choose one below) ☐ QuantiFERON ☐ T-SPOT □ Complete TB Screening Form → **For NEGATIVE Results:** □ **Submit** documentation of negative results. **For POSITIVE Results: (complete both of the following)** □ **Submit** documentation of positive results. □ **Submit** a copy of a **chest x-ray report** taken within the last year. Date of x-ray: _____ X-ray results: _____	Date PPD Given: _____ Date PPD Read: _____ Results in mm: _____ Blood Test Date: (mm/dd/yyyy) _____ ___ Positive ___ Negative **TB SCREENING FORM** Please indicate if you have any of the following symptoms: Yes No ☐ ☐ Chronic cough ☐ ☐ Production of sputum If yes, what color sputum: _____ ☐ ☐ Blood-streak sputum ☐ ☐ Unexplained weight loss ☐ ☐ Unexplained fatigue/tiredness ☐ ☐ Night sweats ☐ ☐ Fever	
ISHIHARA TEST: Required for Clinical Lab Sciences and Cytotechnology Programs only	**Date:** _____ **Passed** ☐ **Failed** ☐	

6/4/21

LOMA LINDA UNIVERSITY HEALTH
Center for Health Promotion

Student Health Service
24785 Stewart St. Evans Hall, Ste. 111
Loma Linda, CA 92354
Phone: (909) 558-8770
Fax: (909-558-0433

Pre-Entrance Health Requirements

PATIENT IDENTIFICATION

Name:

Birth Date:

Medical Record #: