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.	**Immunization #1:** (mm/dd/yyyy) ______________	
----------**OR**---------- **MMR Titer is REQUIRED for the School of Medicine & DPT**	**Immunization #2:** (mm/dd/yyyy) ______________	
☐ **Submit positive blood titer reports for each disease:** Must be **quantitative** (need numerical results) IgG Antibody titers.	**Date of Titer** (mm/dd/yyyy) | Measles ______ | Mumps ______ | Rubella ______	
Tdap (Tetanus, Diphtheria, Pertussis) ☐ Documentation of **Tdap** in the last 10 years.	Date of most recent **Tdap**: (mm/dd/yyyy) ______________	
----------**OR**---------- ☐ **Td** in the last 10 years **AND** One dose of Tdap after age 18.	Date of most recent **Td**: (mm/dd/yyyy) ______________	______________
HEPATITIS B ☐ **Submit** documentation of complete series (3 immunizations required)	**Immunization #1:** (mm/dd/yyyy) ______________	
----------**OR**---------- **Hepatitis B Titer is REQUIRED for the School of Medicine & DPT**	**Immunization #2:** (mm/dd/yyyy) ______________	
☐ **Submit** positive blood titer report (following vaccine series) Must be **quantitative** (need numerical results) Hepatitis B Surface Antibody titer.	**Immunization #3:** (mm/dd/yyyy) ______________	
	Date of Titer: (mm/dd/yyyy) ______________	
VARICELLA (Chickenpox) ☐ **Submit** documentation of 2 Varicella vaccinations given after age 1.	**Immunization #1:** (mm/dd/yyyy) ______________	
---------**OR**--------- **Please note:** History of disease does not fulfill this requirement **Varicella Titer is REQUIRED for the School of Medicine & DPT**	**Immunization #2:** (mm/dd/yyyy) ______________	
☐ **Submit** positive blood titer report: Must be **quantitative** (need numerical results) IgG Antibody titer.	**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	Date PPD Given: ______ | Date PPD Read: ______ | Results in mm: ______	
☐ Complete TB Screening Form →	Blood Test Date: (mm/dd/yyyy) ______ | ____ Positive ____ Negative	

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: ______________

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** ☐

11/2/22JR

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 #: