KUMC Student Health Services - Office: 913-588-1941, Fax: 913-588-1943
Health Requirements for Enrollment – Group C Research and Leadership Students
MSN and DNP Leadership Programs, Psychiatric NP, SON PhD, SOM Graduate and Research Programs, SOM Biostatistics (On-campus), HIM, HI, MS Genetic Counseling, PhD Therapeutic Science, PhD Rehab Science

Student Name: (Please Print)	Date of Birth:

All required immunizations, blood tests and physical exams are available at KUMC Student Health. Please call for appointment and fee schedule. If the following form is completed by your personal health care provider, please remember to provide your immunization record so that your health care provider can certify that the proper immunizations have been given.

1. Flu Vaccine

If your first day of class is between September 1st and April 30th, please attach documentation of the current seasonal influenza vaccination.

2. Immunizations

Immunization Information			
Varicella (Chicken Pox)	Date of Dose #1:	Date of Dose #2:	History of Disease: MM/DD/YYYY
Hepatitis B	Date of Dose #1:	Date of Dose #2:	Date of Dose #3:
Measles, Mumps, and Rubella (MMR)	Date of Dose #1:	Date of Dose #2:	
One adult Tdap. Td or Tdap must be current within the past 10 years.	Date of Vaccination: Tdap: _____ Td: _____		

3. Tuberculin Skin Test (PPD)

Two step testing is required for all new students. This involves two separate PPD tests administered and interpreted within the past 12 months. The most recent PPD should be within the last 3 months. Alternatively, a QuantiFERON or T-Spot blood test within the last 3 months is acceptable ***(attach a copy of lab report)***. TB testing is required annually, thereafter.

TB Test Information				
Step One:	Date Administered:	Date Read:	Induration:	Circle: POS or NEG
Step Two:	Date Administered:	Date Read:	Induration:	Circle: POS or NEG
Or				
Circle One: QuantiFERON or T-Spot		Date of Testing:	Circle: POS or NEG	

4. Required Physical Examination

Physician Statement: I have examined this student and have found no evidence of abnormal findings or limitations. By my signature, I certify the immunization dates listed above.

Assessment Abnormalities: _____
Address: _____
City, State, Zip: _____
Phone Number: _____
Signature: _____
Date: _____

Note: Refusal to comply with immunizations policy at KUMC may result in the inability to provide patient care or participate in scholastic or clinical experiences.