Kaiser Permanente South Bay Medical Center – Employee Health Services

STUDENT HEALTH SCREENING REQUIREMENTS

Student Name: _____ Date of Birth: _____ Unit/Dept: _____

School: _____ Rotation Start Date: _____ Rotation End Date: _____

Please enter **appropriate dates** and **provide written documentation**:

Tdap (Tetanus, Diphtheria, & Pertussis)	**Include:** Written documentation showing adequate vaccination or signed declination form	**Date of Vaccination:**		☐ **Declination Form** **Note:** Students entering MCH (L&D/Post Partum/NICU) or OB/Pediatrics may **NOT** decline Tdap. **No exceptions!**
Seasonal Flu	**Include:** Written documentation showing adequate vaccination	**Vaccine Name:** **Lot #** **Exp. Date:**		**Date of Vaccination:**
Rubeola (Measles)	**Include:** Laboratory evidence of immunity or written documentation showing adequate vaccination	**Lab Evidence of Immunity Date:**	**1st Dose Given Date:**	**2nd Dose Given (>4 weeks later) Date:**
Mumps	**Include:** Laboratory evidence of immunity or written documentation showing adequate vaccination	**Lab Evidence of Immunity Date:**	**1st Dose Given Date:**	**2nd Dose Given (4 weeks later) Date:**
Rubella (German Measles)	**Include:** Laboratory evidence of immunity or written documentation showing adequate vaccination	**Lab Evidence of Immunity Date:**	**1st Dose Given Date:**	
Varicella (Chickenpox)	**Include:** Laboratory evidence of immunity or written documentation showing adequate vaccination	**Lab Evidence of Immunity Date:**	**1st Dose Given Date:**	**2nd Dose Given (4-8 weeks later) Date:**
Hepatitis B	**Include:** Laboratory evidence of immunity or written documentation showing adequate vaccination or signed declination form	**Lab Evidence of Immunity Date:**	**1st Dose Given Date:**	**2nd Dose Given Date:** / **3rd Dose Given Date:** ☐ **Declination Form**

Tuberculosis (TB) Screening (PPD administered intradermally, results measured and recorded in millimeters induration at 48-72 hrs.)	**Negative PPD** (must include written documentation) ☐ non-reactive PPD **within last 12 months** _____mm of induration Date: _____ **AND** ☐ Second non-reactive PPD **within last 24 months** _____mm of induration Date: _____ **OR** ☐ non-reactive IGRA (QFT or T-spot) **within last 12 months**	**Positive PPD** (must include written documentation) ☐ Reactive PPD **and/or** INH Therapy _____mm of induration Date: _____ **AND** ☐ Negative Chest X-Ray Report **within 1 year of starting current Academic Program** Date: _____

By signing below, I am attesting that the above information is accurate and can be made available to Kaiser Permanente at any time during this individual's clinical rotation.

School representative:

_____ _____ _____ _____

Name Signature Phone Number Date