**Medical Clearance and Proof of Immunization**

**Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program: Ascend/RISE Faculty Graduate Student Undergraduate Student 

Staff Other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 1: Immunity to measles, Mumps, Rubella and Varicella** (attach lab reports if available)

**MMR & Varicella Vaccination & Dates**

MMR #1 \_\_\_\_\_\_\_\_\_ MMR #2 \_\_\_\_\_\_\_\_\_ MMR #3 (if given) \_\_\_\_\_\_\_\_

Varicella #1 \_\_\_\_\_\_\_\_\_ Varicella #2 \_\_\_\_\_\_\_\_\_ Varicella #3(if given) \_\_\_\_\_\_\_\_

**OR**

**MMR & Varicella Immunity based on Titer Test results**

Measles Titer (IgG) Result Date:\_\_\_\_\_\_\_ Result: POS NEG 

Mumps Titer (IgG) Result Date:\_\_\_\_\_\_\_ Result: POS NEG 

Rubella Titer (IgG) Result Date:\_\_\_\_\_\_\_ Result: POS NEG

Varicella Titer (IgG) Result Date:\_\_\_\_\_\_\_ Result: POS NEG

**Section 2: Immunity to Hepatitis B** (attach lab reports)

Documentation of complete Hep B series is required for all researchers who might come in contact with blood or blood products.

Hep B #1\_\_\_\_\_\_\_\_\_ (date) Hep B #2\_\_\_\_\_\_\_\_\_\_\_(date) HepB #3\_\_\_\_\_\_\_\_\_\_(date)

**Section 3: Immunity to Tetanus**

Most recent Td booster \_\_\_\_\_\_\_\_(date within last 10 years) Type : Td Tdap (Adacel or Boostrix

**Section 4: Tuberculosis screening skin test ( Chest X-Ray Or Quantiferon Gold**

Tuberculin skin test (within 12 months of the start of program):

Date Placed\_\_\_\_\_\_ Date Read\_\_\_\_\_\_\_ Size \_\_\_\_\_\_\_(mm of induration) POS NEG

Quantiferon Gold: \_\_\_\_\_\_\_\_ (date must be within 90 days of the start of program if skin test is positive)

POS NEG 

**If tuberculin skin test or Quantiferon Gold is POSITIVE a chest x-ray must be done**

Chest X-ray\_\_\_\_\_\_\_\_\_ (date must be within 12 months of program start) Normal Not normal

**(**Attach chest x-ray report if done; attach chest x-ray report if done)

If chest X-Ray is positive

Did the patient complete INH or comparable treatment? Yes No

Is Patient currently free of signs or symptoms of active tuberculosis disease? Yes No

**Section 5. I have used a respirator in the past** Yes No  

**(If yes, patient must compete a fit test at MSU annuall**y)

**Section 6: Health Statement (completed by Health Care Provider)**

The most recent physical examination was \_\_\_\_\_\_\_\_\_\_\_ (date must be within 12 months of start program) for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient’s name)

By my signature below, I certify that this individual is in good health and does not appear to have evidence of an illness or impairment that may pose a risk in the academic animal laboratory setting with

No exceptions. The patient is clear to work in an academic animal laboratory setting and can perform animal care and use activities with no accommodations due to health status

Some Exceptions. The patient can work in an academic animal laboratory setting but requires the following accommodations to mitigate any risks due to health status

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Specify on this document or attach additional information regarding any exceptions or needed accommodations for working in an academic or clinical animal laboratory setting

Clinician name and title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office address and phone number

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_