**Medical Clearance and Proof of Immunization**

**Must complete** [**Occupational Health Risk Assessment and Enrollment**](https://drive.google.com/file/d/1IR8jqIpz0frYHkTh2vQKnPbz4St7gljG/view?usp=sharing) **with your supervisor before pre-employment physical**

 **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 OR Quantiferon** 

Tuberculin skin test #1 (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 patient complete INH or comparable treatment? Yes No

**MEDICAL HISTORY (to be filled out by medical professional**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES** | **NO** | **NA** |
| **History of Immune suppressive medical conditions, including chronic conditions (e.g. renal failure, diabetes mellitus), corticosteroid use, immune suppressive agents, splenectomy, and immune suppressive diseases** |  |  |  |
| **History of allergies, including food, drugs, atopy, dermatitis, eczema, allergic rhinitis, asthma, and sensitivity to latex products (specify)** |  |  |  |
| **History of allergies to animals, including laboratory animals (state species)** |  |  |  |
| **Current pregnancy for female workers** |  |  |  |
| **History of valvular or congenital heart problems** |  |  |  |
| **History of respirator use.**  **(If yes, patient must complete a fit test at MSU annuall**y)  |  |  |  |
| **Other** |  |  |  |

The most recent physical examination was \_\_\_\_\_\_\_\_\_\_\_ (date must be within 12 months of start program and annually thereafter) ) for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient’s name)**.**  I certify that this individual is in good health and does not appear to have evidence of and 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 with no accommodations due to health status

 Some Exceptions. The patient can work in an academic animal laboratory setting but requires \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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 settings

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

Office address and phone number