Confidential Health Survey 2016
University of Pittsburgh School of Dental Medicine

TO BE COMPLETED BY THE CANDIDATE:

A. CANDIDATE'S FULL NAME (Please print)

_____

Last Name First Name MiddleName

B. I hereby give my full permission to _____
to furnish to the University of Pittsburgh any desired information concerning my medical history.

C. _____ _____
Signature of Candidate Date

_____

TO BE COMPLETED BY THE PHYSICIAN:

Note: The University of Pittsburgh bases its acceptance of applicants upon an appraisal of their character, educational record, aptitudes, physical fitness, and emotional fitness to engage in dental practice, teaching, or research. We consider the following information vital. Please respond to these questions as completely and accurately as possible. We must know a student's health status while caring for patients. This information will be maintained in the student's confidential record in the Office of Student Affairs.

1. Do you have awareness of any condition, past or present, which may interfere with this candidate's ability to participate fully in the educational program of the School of Dental Medicine or in future practice of dentistry? If yes, please explain.

_____

_____

_____

2. Date of candidate's last physical examination_____

Candidates must have a documented physical exam between March 1 and August 19, 2016, within 6 months of the program start date.

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CANDIDATE NAME: _____

The School of Dental Medicine recommends the completion of the following vaccinations, and/or titers showing immunity, prior to matriculation:

Diphtheria, Pertussis, Tetanus-Booster (DPT)
within last six (6) years (2010): _____ Date

Rubella (vaccination or titer) _____ Date

Rubeola (vaccination or titer) _____ Date

Mumps (vaccination or titer) _____ Date

Polio _____ Date

Meningitis _____ Date

Varicella-Zoster (2 dose vaccination or disease **and** current titer)

_____ Date _____ Date 2nd Date (at least 28 days) after initial dose

The School of Dental Medicine requires completion of a **two-step tuberculin test** prior to matriculation. **Yearly one-step tuberculin tests** will be required thereafter.

Date of first test ____/____/____ Result: _____

Date of second test ____/____/____ Result: _____
(1-3 weeks after initial test)
Further tests or treatment recommended: _____

If vaccinated with BCG (Bacillus of Calmette-Guerin), the following will apply:
If vaccinated as a child and have not been skin tested as an adult, receive a two-step tuberculin test and report results above. If vaccinated and have a documented history of a tuberculin skin test greater than 10mm, you must complete an annual surveillance form and provide results of or obtain a baseline chest X-ray. If you have taken INH, provide the dates of treatment: STARTED_____ FINISHED_____.

The School of Dental Medicine requires initiation of a **Hepatitis B vaccination** series before registration for the fall term of the first year and completion of the series before registration for the fall term of the second year. We require that an antibody titer be determined within six (6) months of the last injection of the series. The series need not be completed before this form is returned. When injections are given, please give the student written notice to bring to us.

Injection ONE _____ Date Injection TWO _____ Date

Injection THREE _____ Date Current Antibody titer _____ Date

The School of Dental Medicine strongly encourages students to have yearly immunization against influenza.
It is mandatory that all students/residents carry health insurance to cover hospitalization and physician fees during first professional training.

Physician Name (please print)_____

Physician Office Address _____

Physician Office Phone Number_____

Physician Signature_____ Date _____