UNIVERSITY OF PITTSBURGH SCHOOL OF DENTAL MEDICINE
PHYSICAL AND IMMUNIZATION RECORD

Candidates must have a documented physical exam between August 1, 2024 and June 30, 2025

STUDENT INFORMATION

(ALL FIELDS MUS T BE COMPLETED)

NAME _____/_____/_____
(LAST NAME) (FIRST NAME) (MIDDLE NAME)

ADDRESS _____/_____
(STREET) (CITY/STATE/ZIP)

TELEPHONE _____E-MAIL _____

TO BE COMPLETED BY THE PHYSICIAN:

REQUIRED IMMUNIZATIONS PART I

VACCINE	DATE MM/DD/YY	DATE MM/DD/YY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE[1]
MMR[2] **MEASLES, MUMPS, RUBELLA**	____/____/____	____/____/____	____/____/____
MMRV[2] **MEALES, MUMPS, RUBELLA, +VARICELLA**	____/____/____	____/____/____	____/____/____
MEASLES	____/____/____	____/____/____	____/____/____
MUMPS	____/____/____	____/____/____	____/____/____
RUBELLA	____/____/____	____/____/____	____/____/____
VARICELLA[3]	____/____/____	____/____/____	____/____/____
MENINGOCCOCAL QUADRIVALENT[4] **Highly recommended**	____/____/____	____/____/____	____/____/____

1 IF USING A TITER RESULT/SEROLOGIC EVIDENCE FOR PROOF OF IMMUNIZATION, A COPY OF THE RESULTS MUST ACCOMPANY THIS FORM FOR REVIEW. PLEASE INDICATE THE DATE OF THE TITER IN THE APPROPRIATE FIELD.
2 TWO DOSES OF EITHER MMR/MMRV ARE REQUIRED.
3 HISTORY OF CHICKEN POX, A POSITIVE VARICELLA ANTIBODY, OR TWO DOSES OF VACCINE GIVEN AT LEAST ONE MONTH APART ARE REQUIRED. IN CASE OF HISTORY OF DISEASE, PLACE DATE OF DISEASE IN FIRST DATE FIELD.
4 REQUIRED IF LIVING IN UNIVERSITY HOUSING. TWO DOSES ARE REQUIRED, WITH ONE DOSE ADMINISTRATED AT 16 YEARS OLD OR OLDER.

REQUIRED IMMUNIZATIONS PART II

VACCINE	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY
TETANUS-DIPTHERIA[5]	____/____/____	____/____/____	____/____/____	____/____/____
POLIO[6]	____/____/____	____/____/____	____/____/____	____/____/____
HEPATITIS B[7]	____/____/____	____/____/____	____/____/____	DATE OF POSITIVE LAB/ SEROLOGIC EVIDENCE ____/____/____

5 PRIMARY SERIES WITH DTaP OR DTP AND BOOSTER WITH Td IN THE **LAST 10 YEARS MEETS REQUIREMENT (2015+).**
6 PRIMARY SERIES IN CHILDHOOD MEETS REQUIREMENT; THREE PRIMARY SERIES SCHEDULES ARE ACCEPTABLE. (OPV ALONE ORAL SABIN THREE DOSES] IPV/OPV SEQUENTIAL OR IPV ALONE [INJECTED SALK FOUR DOSES].
7 THREE DOSES OF VACCINE OR TWO DOSES OF ADULT VACCINE IN ADOLESCENTS 11-15 YEARS OF AGE. A COPY OF THE TITER RESULTS **MUST** ACCOMPANY THIS FORM FOR REVIEW. **THIS TITER CANNOT BE DATED PRIOR TO AUGUST 2024.** PLEASE INDICATE THE DATE OF THE TITER IN THE APPROPRIATE FIELD.

REQUIRED TESTING

You must have either the 2 step TB test or Quantiferon Blood Draw completed

TUBERCULOSIS SKIN TEST[8] STEP 1	DATE ADMINISTERED ____/____/____	DATE READ ____/____/____
	RESULT: ☐ POSITIVE ☐ NEGATIVE	INDURATION (IF NONE MARK '0'): _____mm
TUBERCULOSIS SKIN TEST[8] STEP 2	DATE ADMINISTERED ____/____/____	DATE READ ____/____/____
	RESULT: ☐ POSITIVE ☐ NEGATIVE	INDURATION (IF NONE MARK '0'): _____mm
CHEST X-RAY[9]	RESULT: ☐ NORMAL	RESULT: ☐ ABNORMAL
TUBERCULOSIS QUANTIFERON GOLD BLOOD TEST[10]	RESULT: ☐ NEGATIVE	RESULT: ☐ POSITIVE

8 A TWO-STEP TB SKIN TEST IS REQUIRED. STEP 2 MUST BE COMPLETED 1-3 WEEKS AFTER STEP 1 TEST. **THIS TEST CANNOT BE DATED PRIOR TO AUGUST 2024.**
9 REQUIRED IF TUBURCULIN SKIN TEST IS POSITIVE. A COPY OF THE RESULTS MUST ACCOMPANY THIS FORM FOR REVIEW.
10 IF USING QUANTIFERON GOLD BLOOD TEST TO PROVE IMMUNITY, A COPY OF THE RESULTS MUST ACCOMPANY THIS FORM FOR REVIEW.

PHYSICIAN STATEMENT:

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

_____

_____

_____

Date of candidate's physical examination:_____/_____/_____

Physician Name (please print)_____

Physician Office Address _____

Physician Office Phone Number_____

Physician Signature_____ Date _____

IMMUNIZATION EXEMPTIONS:

A written exemption statement must be submitted to the School of Dental Medicine Student Affairs Office for review. Please be aware, if an outbreak of measles, mumps, rubella, or chicken pox occurs, the Allegheny County Health Department may exclude students from classes who do not provide proof of immunity to these circulating diseases. If applicable, you can request this exemption form from Student Affairs at 412- 648-9806.

Upload your health documents in PDF format to Our Records credentialing. If you have questions or concerns contact Kathy Horn at kdh@pitt.edu

Students must submit the **Physical and Immunization Record by June 30.** Students will not be registered for classes until the completed health form has been submitted, reviewed and approved.