

**UNIVERSITY OF PITTSBURGH SCHOOL OF DENTAL MEDICINE  
PHYSICAL AND IMMUNIZATION RECORD**

**Candidates must have a documented physical exam between August 1, 2022 and July 31, 2023**

**STUDENT INFORMATION**

(ALL FIELDS MUST 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 <sup>1</sup>
<b>MMR<sup>2</sup></b> MEASLES, MUMPS, RUBELLA	___/___/___	___/___/___	___/___/___
<b>MMRV<sup>2</sup></b> MEASLES, MUMPS, RUBELLA, +VARICELLA	___/___/___	___/___/___	___/___/___
<b>MEASLES</b>	___/___/___	___/___/___	___/___/___
<b>MUMPS</b>	___/___/___	___/___/___	___/___/___
<b>RUBELLA</b>	___/___/___	___/___/___	___/___/___
<b>VARICELLA<sup>3</sup></b>	___/___/___	___/___/___	___/___/___
<b>MENINGOCOCCAL QUADRIVALENT<sup>4</sup></b> 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 ADMINISTERED 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
<b>TETANUS-DIPHTHERIA<sup>5</sup></b>	___/___/___	___/___/___	___/___/___	___/___/___
<b>POLIO<sup>6</sup></b>	___/___/___	___/___/___	___/___/___	___/___/___
<b>HEPATITIS B<sup>7</sup></b>	___/___/___	___/___/___	___/___/___	DATE OF POSITIVE LAB/ SEROLOGIC EVIDENCE ___/___/___

5 PRIMARY SERIES WITH DTaP OR DTP AND BOOSTER WITH Td IN THE LAST 10 YEARS MEETS REQUIREMENT.

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 2022. PLEASE INDICATE THE DATE OF THE TITER IN THE APPROPRIATE FIELD.

## REQUIRED TESTING

<b>TUBERCULOSIS SKIN TEST<sup>8</sup> STEP 1</b>	DATE ADMINISTERED ___/___/___	DATE READ ___/___/___
	RESULT: <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE	INDURATION (IF NONE MARK '0'): _____mm
<b>TUBERCULOSIS SKIN TEST<sup>8</sup> STEP 2</b>	DATE ADMINISTERED ___/___/___	DATE READ ___/___/___
	RESULT: <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE	INDURATION (IF NONE MARK '0'): _____mm
<b>CHEST X-RAY<sup>9</sup></b>	RESULT: <input type="checkbox"/> NORMAL	RESULT: <input type="checkbox"/> ABNORMAL
<b>TUBERCULOSIS QUANTIFERON GOLD BLOOD TEST<sup>10</sup></b>	RESULT: <input type="checkbox"/> NEGATIVE	RESULT: <input type="checkbox"/> 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 2022.

9 REQUIRED IF TUBERCULIN 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.

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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.

Please send all completed health documents to the Dental Hygiene Program using one of the methods listed below:

**MAIL:** University of Pittsburgh  
School of Dental Medicine  
Dental Hygiene Program  
3501 Terrace Street, B-82 Salk Hall  
Pittsburgh, PA 15261

**FAX:** 412-383-8737

**EMAIL:** kdh@pitt.edu

If you have questions or concerns please contact 412-648-8432.

New students must submit the **Physical and Immunization Record by July 31**. Students will not be registered for classes until the completed health form has been submitted and reviewed.