Eric Cohen
Student Health
Center of USC
Keck Medicine of USC

KIMBERLY TILLEY
Medical Director
Eric Cohen Student Health Center

Keck Medicine of USC

Dear New USC Health Science Campus Student,

I would like to extend a warm welcome and congratulate you on your admission to USC. Whether you are new to USC or attended as an undergraduate, I would like to introduce you to the Eric Cohen Student Health Center (ECSHC) of USC, your Medical Home on the USC Health Sciences Campus.

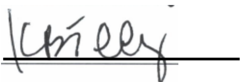
Please take the time to review this packet carefully and be sure you meet all of our health clearance requirements. If you have any questions, please visit http://ecohenshc.usc.edu/health-clearance/ or contact us via phone at 323-442-5980 or by email at ecohenshc.immunizations@med.usc.edu.

The Eric Cohen Student Health Center is not a typical student health center. We are a small health center serving only the graduate students on USC's Health Sciences Campus. We offer comprehensive primary care as well as a fully staffed counseling center on the premises. Before your first day of class, you can visit us for immunizations, TB testing, and lab work only. You will be charged a $30 visit fee plus any charges associated with the immunizations, TB or lab work received. Please visit http://ecohenshc.usc.edu/health-clearance/prices/ for price information. Once your classes begin, you will have access to all of the medical and counseling resources at our health center. More information about our services can be found on our website https://ecohenshc.usc.edu/.

We are an accredited medical home clinic by the Accreditation Association of Ambulatory Health Care (AAAHC), which means we offer the highest standards for patient care and patient experience. As your Medical Home, we offer patient-centered care, with an emphasis on evidence-based medicine, personal attention, and customer service. We hope you will use the clinic as your new primary care provider, not just when you are sick or injured. We love to see our patients and get to know them and hope you will enjoy your experience with us.

Come by and visit us, we would love to see you.

Fight On!



Kimberly Tilley, MD
ECSHC Medical Director

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Health Clearance Packet 2017 – Version B

All USC Health Science Campus students entering into one of the clinical programs below must fill out ALL sections of this packet and submit with accompanying documentation to ECSHC either by mail or email by July 17, 2017.

Program	Deadline	Program	Deadline
Physical Therapy	July 17, 2017	Pharmacy	July 17, 2017

Mail:
Eric Cohen Student Health Center of USC
Attn: Health Clearance Team
1510 San Pablo St. Suite 104
Los Angeles, CA 90033

Email:
To: ecohenshc.immunizations@med.usc.edu
Subject: Academic Program, Student ID #
Format: Documents must be in PDF Format
We do not accept faxed document

FAQ:

1. **My deadline to submit my health clearance packet is [—–] but I am unable to meet that deadline. Can I turn in my paperwork later?**
   - *Yes, you can. However, if you submit your paperwork after the deadline, you may not be cleared in time for your program to assign you to rotate at your clinical facilities. Please submit your paperwork as soon as possible.*

2. **What is a titer?**
   - *A titer is a laboratory test that measures the presence and amount of antibodies in blood. A titer may be used to prove immunity to disease. A blood sample is taken and tested.*

3. **What do you mean by "attach full lab results"?**
   - *We need a lab report which is generated by the lab that tested the blood sample. The report must include the patient name, test name, test date, exact values, and reference ranges.* ***We will not accept flow charts.*** *Please see example of a valid lab report:*

Laboratory Report

Name: PATIENT, TEST4
Id: 1797639545
Age: 34 yrs at result time
DOB: 8/1/1982
Sex: F

Ordered by: [redacted] - 0000
Order #: L541842-98
Collected: 10/31/2016 1:50 PM
Received: 10/31/2016 1:50 PM

IT TESTING *** NO SPECIMEN SENT

8624 - Mumps Virus Antibody IgG #8624

Reported: 10/31/2016 1:56 PM
Status: Final

IT TESTING *** NO SPECIMEN SENT

Test Name	Result	Flags	Reference Range
MUMPS VIRUS ANTIBODY (IGG)	1.68		

```
Index          Interpretation
< or = 0.90    Negative
0.91-1.09      Equivocal
> or = 1.10    Positive
A positive result indicates that the patient has antibody
to mumps virus. It does not differentiate between an
active or past infection. The clinical diagnosis must
be interpreted in conjunction with the clinical signs
and symptoms of the patient.
```

4. **What are the test numbers for the titers?**
   - *Measles IgG (Quest #964, LabCorp #096560)*
   - *Mumps IgG (Quest #8624, LabCorp #096552)*
   - *Rubella IgG (Quest #802, LabCorp #006197)*
   - *Varicella IgG (Quest #4439, LabCorp #096206)*
   - *Hepatitis B Surface Antibody* ***Quantitative Only*** *(Quest #8475, LabCorp #006530)*

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Last Name:		**First Name:**	
DOB:		**USC Student ID:**	
Academic Program:		**Anticipated Graduation Year:**	
Cell Phone:		**USC Email:**	

A. MMR (Measles, Mumps, Rubella) - 2 doses of MMR vaccine **AND** serologic proof of immunity for Measles, Mumps and Rubella

	Vaccine	Date	
2 doses of MMR Vaccine	MMR Dose #1	/ /	
	MMR Dose #2	/ /	
	Test	Date	Results (attach full lab results)
Measles positive serology	Serologic Immunity (IgG, antibodies, titer)	/ /	❑ Positive ❑ Negative
Mumps positive serology	Serologic Immunity (IgG, antibodies, titer)	/ /	❑ Positive ❑ Negative
Rubella positive serology	Serologic Immunity (IgG, antibodies, Titer)	/ /	❑ Positive ❑ Negative

B. Varicella (Chicken Pox) – 2 doses of vaccine **AND** positive serology

	Vaccine	Date	
2 doses of Varicella Vaccine	Varicella Vaccine #1	/ /	
	Varicella Vaccine #2	/ /	
	Test	Date	Results (attach full lab results)
Varicella positive serology	Serologic Immunity (IgG, antibodies, titer)	/ /	❑ Positive ❑ Negative

C. Hepatitis B Vaccination – 3 doses of vaccine followed by a QUANTITATIVE Hepatitis B Surface Antibody (titer) drawn at least 30 days after 3rd dose. If negative, complete one additional booster shot of Hepatitis B Vaccine followed by a QUANTITATIVE Hepatitis B Surface Antibody (titer) after 30 days. If Hepatitis B Surface Antibody is negative after second QUANTITATIVE Hepatitis B Surface Antibody, please contact the Eric Cohen Student Health Center via email.

	Vaccine/Test	Date	
Primary Hepatitis B Series (Must fill out this section)	Hepatitis B Vaccine Dose #1	/ /	
	Hepatitis B Vaccine Dose #2	/ /	
	Hepatitis B Vaccine Dose #3	/ /	
	QUANTITATIVE Hep B Surface Antibody	/ /	Results (attach full lab results) ❑ Positive ❑ Negative
Secondary Hepatitis B (Fill out this section if first Quantitative Hep B Surface Antibody is Negative)	Hepatitis B Vaccine Dose #4	/ /	
	QUANTITATIVE Hep B Surface Antibody	/ /	Results (attach full lab results) ❑ Positive ❑ Negative
Chronic Active Hepatitis B (fill out only if applicable)	Hepatitis B Surface Antigen	/ /	Results (attach full lab results) ❑ Positive ❑ Negative
	Hepatitis B Viral Load	/ /	
	Hepatitis B E Antigen	/ /	

D. Tetanus-diptheria-pertussis - One (1) dose of Tdap from 2006 or later. If the last Tdap is more than 10 years old, please receive an additional TD or TDAP vaccine.

	Vaccine	Date
	Tdap Vaccine (Adacel, Boostrix, etc from 2006 or later)	/ /
	Td Vaccine (if more than 10 years since last Tdap)	/ /

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E. TUBERCULOSIS SCREENING: Please answer the questions below. Your answers will determine the type of tuberculosis test you need to submit.

1.	Have you ever had a positive PPD/TB skin test?	❑ Yes	❑ No
2.	Have you ever had the BCG vaccine for tuberculosis?* (see below)	❑ Yes	❑ No
3.	Are you a member of a TB high-risk group?** (see below)	❑ Yes	❑ No
4.	Have you ever been treated for tuberculosis/received INH treatment?	❑ Yes	❑ No

**BCG, or bacille Calmette-Guerin, is a vaccine for tuberculosis (TB) disease. Many foreign-born persons have been BCG-vaccinated. BCG is used in many countries with a high prevalence of TB to prevent childhood tuberculous meningitis and miliary disease (derived from the CDC).*

*** You are a member of a high risk group if you were born in or resided in countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, you are part of a high risk group if you were born in or resided in countries EXCEPT: AMERICAN SAMOA, AUSTRAILA, CANADA, BELGIUM, DENMARK, FINLAND, FRANCE, GERMANY, GREECE, ICELAND, IRELAND, ITALY JAMAICA, LIECHTENSTEIN, LEUXEMBOURG, MALTA, MONACO, NETHERLANDS, NORWAY, SAN MARINO, SAINT KITTS AND NEVIS, SAINT LUCIA, SWEDEN, SWITZERLAND, UNITED KINGDOM, USA, VIRGIN ISALNDS (USA), or NEW ZEALAND. For example, if you were born in the USA, then you are NOT part of a TB high-risk group. You would answer 'No'.*

☐ If you answered **YES** to **QUESTIONS 1 or 2 or 3**, please submit a T.Spot.TB® or the QuantiFERON®-TB Gold IGRA lab test result that was taken within 3 months of your academic start date (Full lab results must be submitted).

❑ TSPOT	Test Date: / /
❑ QUANTIFERON	❑ Positive ❑ Negative

☐ If you answered **YES** to **QUESTION 4**, regardless of any other answer, please submit a chest x-ray report taken within 11 months of your program start date **AND** a past medical history of your positive PPD.

Test Date: / /	Result:

☐ If you answered **NO** to **QUESTIONS 1 and 2 and 3 and 4**, you can either:

Option 1: Submit a T.Spot.TB® or the QuantiFERON®-TB Gold IGRA lab test result that was taken within 3 months of your academic start date (Full lab results must be submitted).

❑ TSPOT	Test Date: / /
❑ QUANTIFERON	❑ Positive ❑ Negative

OR

Option 2: Submit a two-step PPD Skin test where your first TB skin test is placed and read anytime within 11 months of your program start date (this is PPD #1 below) and your second TB skin test is placed and read within 3 months of your program start date (this is PPD #2 below).

A two-step PPD skin test is two PPD tests done no sooner than one week apart. That means one placement & one reading, then at least a one week waiting period, then another placement and reading

PPD #1 Date Placed: / /	PPD #1 Date Read: / /	Induration & Result:
PPD #2 Date Placed: / /	PPD #2 Date Read: / /	Induration & Result:

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F. PHYSICAL EXAM: To be performed by an M.D., P.A., N.P., or D.O.

VITALS: B/P: ___________**Height** __________**Weight** __________**Pulse** __________**Resp.**________ **Temp.**____________

Please check box if patient is within normal limits.

If patient is not within normal limits, please include a detailed description of any abnormal findings.

GENERAL	❑ **WNL**	____________________
HEENT	❑ **WNL**	____________________
CHEST/LUNGS	❑ **WNL**	____________________
CARDIOVASCULAR	❑ **WNL**	____________________
ABDOMEN	❑ **WNL**	____________________
MUSCULOSKELETAL	❑ **WNL**	____________________
SKIN	❑ **WNL**	____________________
NEUROLOGIC	❑ **WNL**	____________________
MENTAL STATUS	❑ **WNL**	____________________

Any restrictions on physical activity?

❑ Yes ❑ No

Any recommendations for medical care?

❑ Yes ❑ No

(Explain any restrictions and recommendations)

____

____

____

____

Date Examined___________________________________

Address____

____

____

Provider Name___________________________________

Provider Signature________________________________