Student Health Service
Evans Hall, Room 111
Loma Linda, CA 92350
Phone: (909) 558-8770
Fax: (909) 558-0433
http://www.llu.edu/llu/studenthealth

Dear Student,

We, at Student Heath Service, want to warmly welcome you to Loma Linda University! It is our privilege to provide your primary healthcare during your education program.

Loma Linda University is unique and comprehensive in its approach to student healthcare and well-being. There are specific immunization requirements that you will need to meet prior to becoming a student, and these are outlined on page two. Please read the information carefully and pay special attention to the deadlines described. The pre-entrance health requirements form must be submitted **3 weeks prior to the beginning of registration.**

To process your Pre-Entrance Health Requirements form:

Step 1: Print Pre-Entrance Health Requirements form.

Step 2: Obtain a physician signature on the Pre-Entrance Health Requirements form, **or** attach legible proof of vaccination/s *(must include the date in a **mm/dd/yyyy** format on immunization records/labs).*

Step 3: Fax or mail your Pre-Entrance Health Requirements form to Student Health Service *(assure form is legible).* To complete your registration, this form must be received in our office **3 weeks prior to the beginning of registration.**

Fax to**:** (909) 558-0433 **or** mail to**:** Student Health Service
Evans Hall, Room 111
Loma Linda, CA 92350

PLEASE NOTE: Updates to your student portal occur as processing takes place. Please refer to your student portal for status, as calling will only delay your process. Clearance will generally be completed just prior to registration.

At Student Health Service, we want to ensure that you receive quality care, and we look forward to contributing to a happy, healthy academic year.

Best regards,

Student Health Service

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PRE-ENTRANCE HEALTH REQUIREMENTS

The following documentation is REQUIRED FOR ALL PROGRAMS and must have either a physician's signature **or** be accompanied by a valid, legal immunization record. This documentation must be returned to Student Health Service. **Send to above address or fax**. (Please Print)

Name: ______________________________ Gender: ________
Last First Middle Initial M/F

Birth Date: ____________________ ID# or SS#: ____________________ Starting Program/Classes: ____________/____________
Year Quarter

Check which school you are attending and if requested, specify your program:

☐ Medicine ☐ Public Health ☐ Allied Health - specify program: ____________________
☐ Nursing ☐ Religion ☐ Dentistry - specify program: ____________________
☐ Pharmacy ☐ Science & Technology ☐ Non-Degree (Only TB Skin Test is needed for non-degree students)

REQUIREMENTS FOR ALL PROGRAMS	DATE RECEIVED:			BY:
MMR (Measles, Mumps, Rubella) Proof of 2 MMR vaccinations given after 1956.	#1:			
☐ In lieu of immunization documentation, **submit** titer laboratory report: Date __________	#2:			
TDAP Must be current within 10 years.				
TUBERCULIN SKIN TEST (PPD Mantoux) Must be current within 12 months prior to starting a program and/or classes.	Date Given:	Date Read:	Results in mm:	
For LLU Office Use Only	Date Given:	Date Read:	Results in mm:	
☐ Previous positive PPD: Date:__________ Positive due to: [ ] Exposure [ ] BCG	Date Given:	Date Read:	Results in mm:	
☐ If previous positive skin test, copy of chest x-ray report taken within the last year must be attached.	Date Given:	Date Read:	Results in mm:	
	Date Given:	Date Read:	Results in mm:	
☐ Sent for chest x-ray: Date:__________	Date of x-ray:	X-ray results:		
HEPATITIS B Series of 3 injections required for all students. Series does not have to be complete before entrance.	#1:			
☐ In lieu of immunization documentation, submit titer laboratory report: Date:__________	#2:			
	#3:			
VARICELLA (CHICKENPOX) History of disease? YES___ NO___ If NO, then you must show documentation for a series of two injections.	#1:			
☐ In lieu of immunization documentation, submit titer laboratory report: Date:__________	#2:			
ISHIHARA TEST: Required for Clinical Lab Sciences and Cytotechnology Programs.		Date:	Passed:	Failed:

I certify these immunization records are accurate. (Dates need to match)

Physician's Signature:______________________________ Date:______________

License Number:____________________ State:________ Phone #:____________________

LLU OFFICE USE ONLY		
Temp. Cleared:	Letter Sent:	See Additional Sheet ☐