Infectious Disease Requirements

EMS Students Assigned Clinical Experience at UVa Health

______________________________ ______________ ____________

Please Print Full Name Date of Birth Date

THE FOLLOWING REQUIREMENTS ARE MANDATORY AND MUST BE MET WITHOUT EXCEPTION BEFORE PARTICIPATING IN CLINICAL TIME AT UVA HEALTH.

IMMUNIZATIONS

1. Flu vaccine. Date of vaccination: ________________ (Required annually)

2. Td (diphtheria-tetanus) or Tdap.
EMS students are advised to receive a booster dose every ten years.

Date of Last Booster: ________________ **Type**: ☐ **Td** or ☐ **Tdap**

3. Measles, Mumps, and Rubella (MR or MMR are acceptable)
Two (2) doses of the vaccine are recommended unless:

- **a.** Born prior to 1957, only one vaccine is needed. **Date of MMR**: ________________
- **b.** Born in or after 1957 and has received two doses, including a booster, since 1980. **Date of Last Booster**: ________________
- **c.** Documented evidence of vaccination or disease (by laboratory report):

  Date Lab Test Done: ________________ **Results of Lab Test**: ________________

  Comments: ____

4. Hepatitis B
Three (3) doses of the vaccine are recommended for all EMS students who are not protected against the disease.

Date of Last Booster: ________________

Comments: ____

5. Varicella
Two (2) doses of the vaccine or documented evidence of disease are recommended for all EMT students who are not protected against the disease.

Disease Date: ________________ or **Date of booster**: ________________

Comments: ____

6. COVID-19 - (UVa Health no longer mandates this vaccine as of 8/24/2023).

Booster date (latest): ________________

7. Tuberculosis Screening - Documentation
Submit documented evidence of an intermediate-strength PPD skin test done within the last year and annually. QuantiFERON -TB Gold test, and annual chest X-Ray are also accepted. Please provide documented evidence along with this form.

- **a. Date of PPD Skin Test**: ________________ **Results of Skin Test**: ________________
- **b. QuantiFERON -TB Gold Test date**: ________________

  With a history of positive PPD, documentation of a chest x-ray report showing no active disease after positive PPD and a current annual assessment should be submitted.

- **c. Chest X-Ray Results**: ________________

______________________________ ______________

Physician Signature or Designee Date

______________________________ ______________

Physician Printed Name or Designee Phone Number