



**Student Health Center**

5151 State University Drive, Los Angeles, CA 90032-8411

Information (323) 343-3300

Appointments (323) 343-3302

FAX: (323) 343-6557

**HEALTH REQUIREMENTS FOR REGISTRATION CLEARANCE  
English Language Program (ELP)**

Verification of freedom from tuberculosis and of being immunized for measles, rubella and/or hepatitis B are required of all new students enrolled in English Language Program (ELP). You are required to submit this completed form on or before the **first day of the term. Please take this form to your doctor before leaving your country.**

Student's Name \_\_\_\_\_  
Print Last Name Print First Name Print Middle Name

CIN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Telephone # (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female  
Month Day Year

**THIS SECTION TO BE COMPLETED BY A MEDICAL PROVIDER IN YOUR COUNTRY OR ATTACH VERIFICATION (MEDICAL RECORDS) TO THIS FORM**

**IMMUNIZATIONS:**

Rubella: **(Required of all new international students born after 12-31-1956)**  
Date Immunization Given #1 \_\_\_\_\_ #2 \_\_\_\_\_  
OR  
Date of Immunity Test \_\_\_\_\_ Result \_\_\_\_\_

Measles (Rubeola) **(Required of all new international students born after 12-31-1956)**  
Date Immunization Given #1 \_\_\_\_\_ #2 \_\_\_\_\_  
OR  
Date of Immunity Test \_\_\_\_\_ Result \_\_\_\_\_

Hepatitis B **(Required only if student is 18 years of age or younger)**  
Date Immunization Given #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_  
OR  
Date of Immunity Test \_\_\_\_\_ Result \_\_\_\_\_

**FREEDOM FROM TUBERCULOSIS:**

I certify that the above-named patient is free from active tuberculosis as determined by:

**Check One:**

- Negative chest x-ray or QuantiFERON taken within the past year. Date taken: \_\_\_\_\_
- Negative tuberculosis skin test given within the past year.  
Date given \_\_\_\_\_ Date read \_\_\_\_\_ Induration \_\_\_\_\_ mm

Signature of Medical Doctor \_\_\_\_\_

Print Name \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_



**To be completed by Cal State LA Student Health Center**

Verification approved  Verification not approved – Reason \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Forms/registration/TB-MMR Reg Clearance ELP/02-18



Accredited by Accreditation Association  
for Ambulatory Health Care, Inc.

## STUDENT HEALTH CENTER SERVICES

### **For students who have completed front page:**

- Please mail, FAX, or hand carry front page of this form along with any necessary attachments or health records showing proof of TB clearance, immunization, and/or immunity testing. This form and any health records you submit must be signed and dated by a licensed health care provider with the official seal or stamp of the health care provider's clinic. **Please write your name, CIN, and date of birth in all attachments.**

### **Mailing address:**

Student Health Center ATTENTION: MEDICAL RECORDS  
California State University Los Angeles  
Los Angeles, CA 90032-8411  
USA

**FAX number: (323) 343-6557 Please write your name, CIN, and date of birth in all attachments.**

If you wish to submit this form and health records on campus, the SHC is located on the main walkway between the Career Development Center and the Annenberg Science Complex.

A SHC nurse will verify your records. If your records are not acceptable, the SHC will request additional information from you.

### **For students who need a TB skin test, lab test, or chest x-ray for TB clearance and/or immunizations:**

These services are available at the SHC. Please call (323) 343-3302 for an appointment and fee information. Acceptable methods of payment are cash and check. When paying by cash, exact change is preferred.

**Students must present proof of payment of registration fees for the current semester they are requesting the services along with a picture identification card.**

For additional information call (323) 343-3300 or visit our website  
<http://www.calstatela.edu/studenthealthcenter>