**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
## Professional and Global Education (PaGE) International

Verification of freedom from tuberculosis and of being immunized for measles, rubella, and hepatitis B are required of all new students enrolled in PaGE International Programs. 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 _____

*Official Stamp or Seal*
**REQUIRED**

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 Intl/02-18

**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