LIBERTY UNIVERSITY | COLLEGE of OSTEOPATHIC MEDICINE

MATRICULATION STUDENT REQUIREMENT PACKET

LIBERTY UNIVERSITY
COLLEGE *of* OSTEOPATHIC MEDICINE

Student History and Physical Report

STUDENT INFORMATION	
Full Name:	*Anticipated Year of Graduation:*
Address:	
LUCOM Email:	*Phone Number:*
Birth Date:	*Sex:* Male ▼ *Marital Status:* Single ▼
Emergency Contact:	*Emergency Phone Number:*

STUDENT COMPLETES THIS SECTION - *following the completion of the required history and physical*

I, _____, have had a complete history and physical, tests and immunizations required by LUCOM.

After having read the technical and health requirements for admission, and completing this exam, I, _____, meet all technical and health requirements and am free of contagious disease that would pose a risk to patients.

Student Signature:_____ Printed Name:_____ Date:_____

PHYSICIAN COMPLETES THIS SECTION – *following results*

1. Following the history and physical and availability of required tests performed, the physician should complete this section.
2. Medical records documenting the results of the student's medical history and physical examination should be attached and sent to the college.
3. The physician should read all the accompanying technical and health standards prior to completion.

Heart rate: ____ BP:_____ Ht._____ Wt. _____ BMI _____

I have found the student to be in good health. ☐ Yes ☐ No

I have read LUCOM's technical and health requirements, and I see no condition that hinders the student's ability to meet those requirements. Yes ☐ No ☐

Upon examination and after review of the required tests, I have found the student to be free from clinically apparent contagious diseases. ☐ Yes ☐ No

If the student chooses to participate in an exercise program offered by LUCOM that is of moderate intensity, I find no medical conditions that would place the student at risk. ☐ Agree ☐ Disagree

Provider Signature:_____ Printed Name:_____ Date:_____

**This form must be completed and signed by both the student and the provider. Please print name and include licensure.*

This form should be uploaded into the Complio portal.

THIS FORM IS FOR MEDICAL STUDENTS ONLY
IMMUNIZATION RECORD

Student Health Requirements

Student health forms (physical exam and immunization records) are due by the deadline on your **MyLU Admissions Portal**.

Forms are to uploaded to your Complio Account.

It is important that each student verify that all forms are filled out completely and that they are dated and signed by the physician. Incomplete or unsigned forms will not be accepted. The form will be returned to the student. Such action does not change the due date for the documents and failure to meet the required deadlines could result in the rescinding of LUCOM acceptance.

Any requests for extension of the deadline should be addressed to the Office of Student Health Records & Outreach at LUCOMStudentHealth@liberty.edu.

IMPORTANT: ***LUCOM does not automatically waive immunizations or student health requirements. LUCOM is not responsible to secure or approve educational opportunities that are not in compliance with immunization policies.***

Required laboratory evaluations and immunizations are subject to review and change annually based on recommendations from the Centers for Disease Control (CDC), the United States Prevention Task Force (USPTF) and other public health agencies. Students will be notified of any changes and will be required to comply with any mandated changes upon receipt of notice from LUCOM.

Current LUCOM Requirements:

History and Physical examination: Each student must have a comprehensive history and physical examination performed by a licensed allopathic or osteopathic physician, nurse practitioner, or physician's assistant after acceptance and before matriculation into the COM. The examination must be completed within the timeline detailed above. This examination must establish and the examining physician must verify that the student health status is adequate to meet the demands of the curriculum; that they are clinically free of contagious disease that would pose a risk to patients and that the student satisfies the health and technical requirements for admission, education, and graduation detailed in the academic catalog. A signed copy of the physician's medical record of the H & P along with documentation of immunizations and lab reports demonstrating immunity and titers when applicable must be uploaded to the verifying agency.

Please note: Immunizations and Titers are not the same. Titers are blood test that your physician must order to show you are immune.

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IMMUNIZATION RECORD

Immunization Requirements:

TB Skin Test or Immunoassay (Blood Test):

- ***An Annual Test is required of all students***
- ***It is the student's responsibility to obtain the test from a health care provider and report the results in writing to LUCOM***

Each student must supply to the COM written documentation of the date of the test placement, date of interpretation, and the results. In replacement for obtaining a new TB skin test, the student may supply documentation of a PPD skin test previously performed within 6 months of the date of matriculation!

- **Students with a history of a positive PPD skin test (> 10mm induration) should not repeat the test.**
- **Students with a history of a positive PPD will be required to submit the results of a chest x-ray which documents absence of active disease obtained after January 1st of the year of matriculation .**
- **Students with new positive PPD results or those with a positive chest x-ray must follow up with the health department or their personal physician and present documentation of completion of treatment by a physician or an ongoing treatment plan and compliance for consideration of admission.**

A history of immunization with BCG as a child or adult (>5 years previously) does not remove the requirement for Immunoassay testing and appropriate follow up.

- **Students with a positive PPD and negative CXR will be required to submit a TB questionnaire filled out after examination by a physician and following current CDC guidelines. An annual CXR and TB questionnaires will be required while at LUCOM.**

Diphtheria, Pertussis and Tetanus Toxoid:

- **The student must submit written documentation of completion of the initial immunization series with DTP or TDaP.**
- **The receipt of a Tdap booster within the past 10 years.**
- **The date of each immunization is required to be documented.**

Measles, Mumps, Rubella (MMR):

- **The student must have written documentation of receiving two (2) Rubeola, Rubella and Mumps (MMR) vaccine(s). (Individual or combination immunizations).**
- **The date of each immunization is required to be documented.**
- **The student must have titers that demonstrate immunity to measles, mumps, and rubella or immunization boosters may be required.**
- **Students with prior documentation of immune status may submit that documentation in place of new titers.**

Polio (OPV/IPV):

- **The student must have written documentation of receiving an initial series of three (3) IPV or OPV immunizations plus at least one booster immunization.**
- **The date of each immunization is required to be documented.**

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Varicella:

- **The student must have written documentation of receiving two (2) Varicella immunizations.**
- **The date of each immunization is required to be documented.**
- **The student must have titers that demonstrate immunity to Varicella.**
- **Students with prior documentation of immune status may submit that documentation in place of new titers.**

Hepatitis B:

- **The student must have written documentation of receiving three (3) hepatitis B injections.**
- **The date of each immunization is required to be documented.**
- **The student must have documentation of laboratory titers (Hepatitis B surface antibody) that demonstrates immunity to hepatitis B.**
- **Students with prior documentation of immune status may submit that documentation in place of new titers.**
- **Students who have received the initial series of Hepatitis B vaccine and do not seroconvert to demonstrate immunity will be required to repeat the complete series of three immunizations.**

If a student does not seroconvert and demonstrate immunity eight weeks after completion of a second series of immunizations, they will be considered at risk for acquiring HBV. The student will meet with the Associate Dean for Clinical Affairs. Current recommendations and additional education on universal precautions, risk avoidance, and treatment options if exposed to HBV will be provided to the student. The student will sign documentation of informed consent to continue their education, acknowledging the medical risk and receipt of this information, but they will not be required to continue additional HBV immunizations.

Influenza **(Not required for admission):**

- **Annual influenza immunization is REQUIRED by LUCOM.**

This immunization is recommended for all health care workers annually and is required by LUCOM for all health care workers and students.

Additional immunizations: If mandated by state or federal health care agencies or affiliated clinical partners of LUCOM, additional immunizations may be required of LUCOM students.

Recommended Immunizations:

Meningococcal (Hib): Recommended for all health care workers.

Human Papillomavirus (HPV): Recommended for all health care workers.

Typhoid Fever: Recommended for those students who anticipate completing elective rotations in tropical climates or who plan to participate in medical outreach experiences while a student at the COM.
Yellow Fever: Recommended for those students who anticipate completing elective rotations in tropical climates or who plan to participate in medical outreach experiences while a student at the COM.

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Hepatitis A: Recommended for those students who anticipate completing elective rotations in underserved, tropical, or third world locations or who plan to participate in medical outreach experiences while a student at the COM.

Documentation of Immunity:

- **Students will not be allowed any patient care activities until all required immunizations have been administered and proof of immunity is established, including but not limited to early clinical experiences, health care outreach events, international outreach trips, clinical rotations, etc.**
- **Failure to begin clinical experiences as scheduled in the curriculum does not entitle the student to make up the missed experiences, could result in failure of the course, academic probation, or dismissal from the COM.**

Regulatory, legislative, institutional, administrative authorities require that LUCOM students demonstrate immunization, immunity, or protection from multiple contagious diseases before being allowed to perform clinical rotations in the institutions utilized by the COM for the education of its students. LUCOM requires that all students, prior to beginning any clinical education or experience present proof of immunity or protection against acquiring or spreading the following infections or micro-organisms: Varicella, Measles, Mumps, Rubella, and Hepatitis B.

Summary of Minimum Immunizations Required:

1. **Immunization records showing completed MMR, Varicella, DTP, HepB and Polio vaccination series.**
2. **Copies of titers for MMR, Varicella, and Hepatitis B**
3. **Documentation of Tdap booster within the past ten years**
4. **At least two negative PPD tests for TB or negative Immunoassay test. Testing to be no earlier than 6 months before matriculation.**

Please note: Immunizations and Titers are not the same. Titers are blood test that your physician must order to show you are immune.

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IMMUNIZATION RECORD

Parts I & II: (MUST BE COMPLETED, A CERTIFIED COPY OF LAB RESULTS INCLUDED AND SIGNED BY YOUR HEALTHCARE PROVIDER).

Student Name_____ _____ _____
Last First Middle

Date of Birth ____/____/____ LU ID Number: _____
Month Day Year

PART I: Tuberculosis Testing Form (Must be completed no earlier than Jan. 1 of the year of matriculation)

Tuberculosis Testing* - (Students MUST undergo *2-step tuberculin skin test or immunoassay blood test; or must be presently undergoing or have completed LTBI treatment):

DOES THE:

- **Student have history of positive PPD/Immunoassay: □ Yes □ No Date: _____/_____/_____ _____MM**
- **Student has recent PPD (Document below) □ Yes □ No**
- **Student Had Immunoassay due to + PPD □ Other: _____**

Tuberculin Skin Test (Must be completed no earlier than Jan. 1 of the year of matriculation)

(Tests must have at least 7 days but not more than 3 months between 1st reading and 2nd placement or the series must be repeated).

Test 1: Date given: ____/____/____ Date read: ____/____/____ Mo Day Yr Mo Day Yr
Result: _____mm □ **Positive** □ **Negative**
(Record actual mm of induration, transverse diameter; if no induration, write "0")

Test 2: Date given: ____/____/____ Date read: ____/____/____ Mo Day Yr Mo Day Yr
Result: _____mm □ **Positive** □ **Negative**
(Record actual mm of induration, transverse diameter; if no induration, write "0")

Immunoassay Blood Test (Must be completed no earlier than Jan. 1 of the year of matriculation)

Date performed: ___/___/___ Date read: ____/___/___ Results: □ Positive □ Negative

Chest X-Ray(This is a requirement if history of POSITIVE TB Skin test or POSITIVE current TB Skin test, or if Immunoassay Blood Test is POSITIVE. (Chest X-ray not required if patient is currently undergoing LTBI treatment.) Chest X-ray must have been performed no earlier than Jan. 1 of the year of matriculation):

Date of chest x-ray: _____/____/____
INH Initiated: Date_____ X _____months. Result: □ Normal □ Abnormal
Date completion anticipated: ____/____/____ Date of completed regimen: ____/____/____

CXR_Previously Treated LTBI

Date and result of last chest x-ray: _____/_____/_____ Result: □ Normal □ Abnormal
Dates (i.e. length) and details (i.e. drugs, dose) of LTBI treatment regimen: ____/____/____ to ____/____/____

Health Care Provider (Signature required as validation of correct immunization information)

_____ _____ _____
(Name) **(Signature)** **(Date)**

FOR LUCOM MEDICAL STUDENT APPLICANTS ONLY

Name: _____ Date of Birth: _____

Required Immunizations (MM/DD/YY)

DTaP Series: ___/___/___; ___/___/___; ___/___/___; ___/___/___; ___/___/___.

Last Tdap booster: ___/___/___. Tdap within the last 10 years is **required**.

Polio: (1) ___/___/___ (2) ___/___/___ (3) ___/___/___ Booster ___/___/___.

MMR: (1) ___/___/___ (2) ___/___/___ Titer Date ___/___/___

Results: Rubeola: Immune _____ Non-Immune ____.
Mumps: Immune _____ Non-Immune ____. **Copy of titers are**
Rubella: Immune _____ Non-Immune ____. **required**.

MMR Booster: **(1) ___/___/___ (2) ___/___/___**
Repeat Titer Date: ___/___/___

Hepatitis-B: (1) ___/___/___ (2) ___/___/___ (3) ___/___/___
Engerix-B ○ Heplisav-B ○
AND Titer Date: **___/___/___ Results:** Immune ___ Non-Immune___
Copy of titer is required. **A positive titer is REQUIRED.**

Hepatitis-B Booster: (1) ___/___/___ (2) ___/___/___ (3) ___/___/___.
Engerix-B ○ Heplisav-B ○
Repeat Titer Date ___/___/___ Results: Immune ___ Non-Immune___

Varicella: (1) ___/___/___ (2) ___/___/___ History of Disease: __/___/___
Titer Results ___/___/___ Immune___ Non-Immune___
Copy of titer is required. **A positive titer is REQUIRED.**

Varicella Booster: (1) ___/___/___ (2) ___/___/___
Repeat Titer Date: ___/___/___ Results: Immune ___ Non-Immune___

MUST BE SIGNED BY A LICENSED HEALTHCARE PROFESSIONAL:

Signature: _____Title: _____Date: _____
Printed Name: _____
Address: _____
Phone: _____


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