University of Incarnate Word
School of Osteopathic Medicine

Dear University of Incarnate Word Student:

Welcome to the University of Incarnate Word (UIW) document tracking service. UIW has contracted with PreCheck/Sentry MD to store and maintain your student health forms for clinical rotations. We are a confidential student health record service. **Students are required to provide proof of the listed health requirements in this packet in order to participate in the Osteopathic programs.** In this packet are the instructions on how to successfully complete the immunization and health requirements.

Step 1: Verify you have registered for the University Incarnate Word Student Check Package:

- Register for the **Background Check. Drug Screen and Immunization Tracking** by going to www.mystudentcheck.com and type 'University of Incarnate Word' in the program field, then select your program from the 'Program' dropdown menu. Select **Background Check, Drug Screen and Immunization Tracking** then click 'Start Application'.
- Please enter all fields when prompted, and then complete your order. You will be emailed a receipt to the email address you provide.

Step 2: Gather Required Health Documents

- Begin by reading each immunization, titer and additional document requirements listed on the following pages of this Health Requirement Packet **(Part I through Part V)**. It is important that you review this material carefully. All items are to be obtained and **submitted to Sentry MD.**

Step 3: Submit all requirements before or by your specified due date to Sentry MD.

- Submit as a PDF attachment via email to UIW@SentryMD.com or upload to the Secure Student Uploader at https://mysentrymd.com/sentrymd.html#/upload/20.

If you have any questions regarding this packet, please email us at UIW@SentryMD.com.

UNIVERSITY OF THE INCARNATE WORD
SCHOOL of OSTEOPATHIC MEDICINE

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SENTRY MD

PART I STUDENT INFORMATION | *This must be completed by Student and submitted to Sentry MD.*

Name: (Please Print)	**UIW ID Number:**
_____ *Last, First, MI*	_____
Date of Birth: ____/____/_____ DD MM YYYY	**Cell Phone:** (__ __ __) __ __ __ - __ __ __ __
Email Address: _____@_____	

PART II ADDITIONAL DOCUMENTATION | *These items must be submitted to Sentry MD via email to UIW@SentryMD.com or to the Secure Student Uploader at https://mysentrymd.com/sentrymd.html#/upload/20.*

1. **CITI Training–**Submit completed CITI Training modules**.** These certifications are completed through CITI programs at https://about.citiprogram.org/ and once completed you will send the certification of your complete score with name to Sentry MD to update your record.
2. **Health Insurance-** Submit a copy of UIW health insurance card OR if you do not have UIW health insurance, you will need to complete the UIW health insurance waiver and submit the completed waiver with a copy of your cards.
3. **BLS for the healthcare Provider CPR-** ONLY BLS through American Heart Association certification is accepted, submit a copy of your BLS card or e-certificate.
4. **Optional-** 3rd year students are to submit copies of their ACLS, PALS, SAMA and Driver's license to your Sentry MD.

PART III STUDENT CONSENT STATEMENT | *This must be completed by the Student and submitted to Sentry MD.*

I have reviewed this immunization history for completeness and agree to release the information listed in the student health requirement packet to authorized members of the University of Incarnate Word staff and authorized staff of cooperating clinical agencies, as directed by UIW throughout the duration I am enrolled.

_____

Student Signature Date

_____

Student Name (Print) DOB

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PART IV STUDENT IMMUNIZATION RECORD | *Please have the following form completed, signed and stamped your healthcare provider OR LEAVE BLANK and submit all requirements listed below on the original forms from the clinic or provider you received them at.*

Last Name:	**First Name:**	**Date of Birth:**

Measles, Mumps and Rubella (MMR): Positive QUANTITATIVE IgG antibody titers are required for Mumps, Measles and Rubella. If a titer results in non-immunity a two-vaccine series and follow-up titer must be completed. *Titers must include numerical result and or numerical reference ranges.

MMR Titer Dates:	MMR 2 Vaccine Series (Optional):	**If Non-immune titer- two-vaccine Series after titer:**
Measles Titer: __/__/____ **Result: ☐Immune ☐ Non-Immune** **Mumps Titer:** __/__/____ **Result: ☐Immune ☐ Non-Immune** **Rubella Titer:** __/__/____ **Result: ☐Immune ☐ Non-Immune** **☐ Attach copy of quantitative titer report**	1). __/__/____ 2). __/__/____	1). __/__/____ 2). __/__/____ ***Submit repeat Quantitative Titer report from the lab 6 weeks after booster.**

Varicella (Chicken Pox): Positive QUANTITATIVE IgG antibody titer is required. If a titer results in non-immunity a two-vaccine series and follow-up titer must be completed. *Titers must include numerical result and or numerical reference ranges.

Varicella Titer Date: __/__/____ **Result: ☐Immune ☐ Non-Immune** **☐ Attach copy of quantitative titer report**	Varicella 2 Vaccine Series (Optional): 1). __/__/____ 2). __/__/____ Date of Chicken Pox (Optional): __/__/____	**If Non-immune titer- two-vaccine Series after titer:** 1).__/__/____2).__/__/____ ***Submit repeat Quantitative Titer report from the lab 6 weeks after 2 doses.**

Hepatitis B: Positive QUANTITATIVE IgG antibody titer is required *If a titer results in non-immunity an additional three vaccine series or Heplisav-B two dose series and follow-up titer must be completed. *Titers must include numerical result and or numerical reference ranges.

HepB Titer Date: __/__/____ **Result: ☐Immune ☐ Non-Immune** **☐ Attach copy of quantitative titer report**	HepB Vaccine Series (Optional): 1). __/__/____ 2). __/__/____ 3). __/__/____ Heplisav- B Vaccine Series (Optional): 1). __/__/____ 2). __/__/____	**If non-immune titer -Repeat full vaccine Series:** 1). __/__/____ 2). __/__/____ 3). __/__/____ ***Submit repeat Quantitative Titer report from the lab 6 weeks after final dose in new series is completed.**

Influenza Vaccine (Flu): Required seasonally, typically by September 30th each year. Declinations are NOT accepted.

Flu Vaccine Date: __/__/____

Tetanus Diphtheria, Pertussis (Tdap): Tdap vaccine within the past ten years is required. TD booster is accepted ONLY IF TDAP ON FILE.

Tdap Vaccine Date: __/__/____ Lot #____ Exp_____	TD Booster (*Tdap must be documented*): __/__/____

Meningococcal (Meningitis): Vaccine must be within past five years for anyone 22 or younger.

Meningococcal Vaccine Date: __/___/___

Poliomyelitis (Polio): Primary vaccine series dates (IPV or OPV) **OR** one booster date is accepted if dated after 1988.

IPV or OPV: 1). __/__/____ 2). __/__/____ 3). __/__/____**OR Polio Booster After 1988:** __/___/___**OR Polio Titer:** __/__/____
Result: ☐Immune ☐ Non-Immune

Tuberculosis Skin Test (PPD/Mantoux): A negative PPD skin test within 12 months OR negative TB Blood test (QuantiFERON or T-spot) within 12 months of the 1st day of class. **Annual update required.**
*If POSITIVE: a Chest X-ray with NEGATIVE results is required. Students with a POSITIVE TB test and NEGATIVE Chest X-ray will also be counseled regarding latent TB and required to comply with Direct Observational Therapy according to CDC guidelines.

TB Skin Plant Date: __/__/__ TB Skin Read Date: __/__/__ **Result: ____mm ☐ Neg ☐ Pos OR** **QuantiFERON TB Gold Date: ___/___/__☐ Neg ☐ Pos OR** **T-Spot Date: ___/___/__☐ Neg ☐ Pos**	**IF positive TB; Chest X-Ray Date:** __/__/____ **Result: ____mm ☐ Neg ☐ Pos**

Primary Care Provider Signature AND Provider's stamp is required for immunizations on this form to be accepted.

PLACE PROVIDER'S STAMP HERE

_____

Provider's Signature *Date*

Provider Name (printed): _____
Phone Number: (____) _____

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PART V PHYSICAL EXAM | *The following form completed, signed and stamped your healthcare provider.* ***REPEAT ANNUALY.***

Last Name:	First Name:	Date of Birth:

The information contained in this form will be used only by the UIWSOM for purposes of determining if a health threat/risk is posed for students or patients during clinical experiences, rotations, or clerkships. This information will remain as part of the secured student file in and will always remain confidential. The program recommends an annual updated medical history, immunizations, and physical examination, but requires the forms be updated if any health status issues changes in the interim.

Student Signature: _____

To be completed and signed by healthcare provider

Height (inches): ____ Weight (pounds): ____ BP:____/____ Pulse:____ Vision: Right: 20/____ Left: 20/____

Enter "NE" if not evaluated

Medical	Normal	Abnormal	Give details of each abnormality
Head, Neck, Face, and Scalp			
Nose and Sinuses			
Mouth, Teeth, Gingiva, and Throat			
Ears – General (canals, drums, etc.)			
Eyes – General (lids, pupils, motions, etc.)			
Lungs, chest, and breasts			
Heart (include estimate of cardiac function)			
Vascular System (include varicosities)			
Abdomen and Viscera (include hernia)			
Anorectal and Pilonidal			
Endocrine System			
Genito-Urinary System			
Upper Extremities			
Lower Extremities			
Spine and Musculoskeletal			
Skin and Lymphatic (include acne)			
Neurological System			
Psychiatric/Behavioral Health			

Are there any conditions, physical and/or emotional, which may interfere with functioning as a health professional student in the classroom or clinic? (Circle one) No Yes

If yes, please describe:_____

Any allergies to medications? (Circle one) No Yes

If yes, please describe:_____

Primary Care Provider Signature AND Provider's stamp is required for immunizations on this form to be accepted.

PLACE PROVIDER'S STAMP HERE

_____

Provider's Signature *Date*

Provider Name (printed): _____

Phone Number: (____) _____

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STUDENT CHECKLIST: Please allow yourself plenty of time for your requirements to be reviewed in case you need additional, vaccines, tests or certifications. **Once received, your documents can take 24 to 48 business hours to be processed.**

- ❑ Student Information is complete (Part I)
- ❑ Submit documentation of completed CITI training modules (Part II)
- ❑ Submit copy of UIW health insurance card or personal health insurance and waiver (Part II)
- ❑ Submit copy of BLS certification (Part II)
- ❑ Student Consent Statement is signed by Student (Part III)
- ❑ Health Requirements in Part IV are complete, and results are signed, dated and stamped by your Health Care Provider or supplemental documents are obtained to meet each requirement (Part IV)
- ❑ Quantitative titer reports for HepB, MMR and Varicella attached (Part IV)
- ❑ Physical exam is complete (Part V)
- ❑ Return your completed forms by scanning as one PDF file and uploading them to https://mysentrymd.com/sentrymd.html#/upload/20 or emailing as a PDF attachment to UIW@SentryMD.com.
  Please email any questions you may have to UIW@SentryMD.com!

PART VI ACCOUNT ACCESS | Please note your account will only be available after you have registered and sent Part I of this packet into Sentry MD. Your account allows you to see your status and download/print documents that have been processed by Sentry MD. Please make sure to submit document requirements to the Upload link https://mysentrymd.com/sentrymd.html#/upload/20 as you are not able to upload directly to your account, all documents are reviewed and processed prior to showing in your account *(processing can take 24 to 48 business hours)*.

Link to Sentry MD system: https://mysentrymd.com/sentrymd.html#/home

1. Enter your User ID: (email address in all lowercase)
2. Click on Set Password
3. Enter your email address (your User ID will be the email address you registered with in all lowercase)
4. You will be sent a token to your email address
5. Enter Token from email onto site
6. Create a Password
7. Click link to go to login screen

Once you are logged into your account, you will note on the landing page how easy it is to see if you are compliant or not with the requirements for your program. A blue checkmark next to each of the requirements means you are compliant. Requirements without the blue checkmark indicate you are missing documentation and these items need your attention.

In addition to viewing your status at any time, you can download and print your landing page checklist and any or all the documents you have submitted by clicking the Documents Button. Only documents that have completed processing will appear in your account; please note processing can take 48 business hours. We hope these tools help you stay on top of your status and keep you compliant with your program requirements.