Barry University
SCHOOL OF PODIATRIC MEDICINE

American DataBank

Initial Compliance Requirement Form

INSTRUCTIONS

Attention
Before you create your account with Barry University School of Podiatric Medicine Immunization Tracking System, please be aware that your yearly subscription fee for using the Tracking System is $24.00. You will need your Credit Card to pay this subscription fee.

Instructions for creating your Immunization Account on the Immunization Tracking System

1. Create your account by clicking "Online Registration" and fill out all of the necessary information.
2. Process your payment by submitting Credit Card information.
3. Please download all necessary forms.
4. Upon completion, all students must provide all necessary forms and documents to American DataBank by scanning and uploading the documents directly into their ITS Profile or via fax at **303-339-7521 or 877-619-4139.**

Instructions for entering your Requirements on the Immunization Tracking System

1. Tdap (Tetanus/Diptheria/Pertussis): Every 10 Years
You must have a Tdap within last 10 years. Please enter the date of your Tdap on this Form and in the Tracking System.

2. Varicella (Chicken Pox): One Time
You must have either 2 doses of the Varicella Vaccine, OR a Varicella Titer with "Reactive (Immune)" result, Or you may submit Proof of Natural Varicella (Chicken Pox) Disease. Please enter the Vaccine date, OR Varicella Titer date with result, OR the Natural Varicella Disease date on this Form and in the Tracking System. **All titers must include a lab report.**

3. Hepatitis B: One Time
You must have a Hepatitis B 3 Shot Series, OR a Hepatitis B Titer with "Reactive (Immune)" result to be compliant. Please enter all 3 Hepatitis B shot dates, OR Hepatitis B Titer date with result on this Form and in the Tracking System. **All titers must include a lab report.**

4. Hepatitis A: Recommended
You are recommended to have a Hepatitis A Vaccine. If you have had a Hepatitis A Vaccine, please enter the date of the Hepatitis A Vaccine on this Form and in the Tracking System.

5. Flu Shot: Annual
You must have a Flu Shot annually. (seasonal flu shot is available beginning in August and expires June 30 of every year). Students are required to have the flu shot during the entire flu season. Please enter the date of your Flu Shot on this Form and in the Tracking System.

6. Measles (Rubeola), Mumps, and Rubella: One time
You must have 2 doses of Measles, Mumps, and Rubella Vaccines or a Titer with "Reactive (Immune)" result for Measles (Rubeola), Mumps, and Rubella. If you have a "Non-Reactive (Not Immune)" Titer result, then you must have a booster. Please enter the date of the vaccinations, OR the Titer date with result on this Form and in the Tracking System. **All titers must include a lab report.**

7. PPD: Annual
You must have a PPD every 12 months. If the PPD is Negative, you are required to have Annual PPD. Please enter the date and Negative result on this Form and in the Tracking System. If a PPD is Positive, you will need a Chest X-Ray with a Negative result (get a new x-ray every two years) to be compliant. Please enter your Positive PPD date, Chest X-Ray date, and result on the Form and in the Tracking System. If you have had a Positive PPD, you are also required to present a Symptom Free document annually. Please enter the Symptom Free document signed Date on this Form and in the Tracking System. **Please make sure to upload the Symptom Free document, or send via Fax 303-339-7521 or 877-619-4139.**

8. Statement of Good Health: One Time
You must present the Statement of Good Health. Please fill out Page 4 (Statement of Good Health) and sign the form. Please enter the form signed date on this Form and in the System. **Also make sure to upload the signed Statement of Good Health Form, or send via Fax 303-339-7521 or 877-619-4139.**

9. Health Insurance: Annual
You must have Health Insurance provided by Barry University, OR Health Insurance Coverage with another Insurance Provider with a Waiver. Please enter the Heath Insurance by Barry University issued date on this Form and in the Tracking System, Or the Waiver signed date on the Form and in the System. If you have a Waiver because of having Health Insurance Coverage with another Insurance Provider, please make sure to enter the Health Insurance Provider name on this Form and in the Tracking System as well. **Please upload a copy of the front and back of your Health Insurance Card or document, or send via Fax 303-339-7521 or 877-619-4139.**

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Barry University School of Podiatric Medicine
(*for all DPM Students*)
IMMUNIZATION RECORD

Name_____Phone:_____Program: POD_____

Date of Birth ____/____/____ **Social Security/Student Number**_____

To be completed and signed by your health care provider or attach a copy of your original immunization record(s).

1.) TETANUS-DIPHTHERIA-PERTUSSIS Booster with Td in the last ten years is required.
a. Tetanus-Diphtheria-Pertussis (Tdap) booster within the last 10 years……..……___/___/___

2.) VARICELLA (Chicken Pox)
a. Immunization Dose #1 ___/___/___ Dose #2 ___/___/___
b. Varicella antibody ___/___/___ **Result*: Reactive___ Non-reactive___
c. Natural ___/___/___ *Please provide a copy of lab work or a numerical result.

3.) HEPATITIS B (Three doses of vaccine or a positive hepatitis surface antibody)
a. Immunization Dose #1___/___/___ Dose #2 ___/___/___ Dose #3___/___/___
b. Hepatitis B surface antibody ___/___/___ **Result*: Reactive___ Non-reactive___
c. Hep A & B ___/___/___ *Please provide a copy of lab work or a numerical result.

4.) M.M.R. (Measles, Mumps, Rubella) Two doses required for students born on/after 1/1/1957.
a. Dose 1 given at age 12-15 months or later……..……....#1___/___/___
b. Dose 2 given at age 4-6 yrs. or later, and at least one month after first dose #2___/___/___
c. MMR antibody ___/___/___ **Result*: Reactive___ Non-reactive___
*Please provide a copy of lab work or a numerical result.

5.) TUBERCULOSIS SCREENING Annual screening
a. PPD skin test Date given ___/___/___ Date read ___/___/___
Result:_____(Record actual mm of indurations; if no indurations, write "0")
b. Second PPD Date given ___/___/___ Date read ___/___/___
Result:_____(Record actual mm of indurations; if no indurations, write "0")
c. Chest x-ray (required every two years if PPD skin test is positive)
Date of chest x-ray ___/___/___ *Result*: Normal____ Abnormal ____
Symptom check list after first year *Result*: Normal____ Abnormal ____

6.) INFLUENZA (H1N1) Annual booster Date given ___/___/___ (At start of flu season)

_____ _____
Name of Health Care Provider (please print) Address
_____

_____ _____ (____) _____
Signature Date Telephone

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Barry University
School of Podiatric Medicine

Student Statement of Good Health
(*Required for all DPM Students*)

Name_____ Phone:_____ Program:_POD__

Student or SS # _____ Sex _____ Birthdate:_____

Height_____Weight:_____ B/P_____ Approx. Year of Graduation_____

This form is to be completed by a medical doctor or licensed practitioner and returned to the School of Podiatric Medicine

Statement of Good Health:

I have examined this student who appears to be in good health and who is physically able to enroll in the School of Podiatric Medicine and perform physical duties which may be required within a health care setting during training.

Health Care Provider (Please sign and place health care provider address and phone number or stamp below).

Name of Provider_____ Address _____

_____

Signature _____ Date_____ Phone_____

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Barry School of Podiatric Medicine Insurance Waiver
Fall 2015- Summer 2016 Academic Year

All students attending the Barry University School of Podiatric Medicine are **required** to provide proof of adequate health insurance in order to maintain their status in the podiatric program. Proof of insurance (copy of front & back of card) and this completed insurance waiver must be received by the School prior to the first fourteen (14) days of the semester or a student may be unable to register for the upcoming semester. NO INSURANCE COVERAGE IS ASSESSED AUTOMATICALLY. YOU MUST ENROLL IF YOU CHOOSE TO PARTICIPATE IN BARRY STUDENT HEALTH INSURANCE.

Failure to comply with the policy will negatively affect the Student's registration.

It is strongly recommended that you verify with your insurance company that your policy covers you/your child for the requirements listed below prior to submitting this waiver.

Existing Coverage Information

Please answer the following questions to determine if your current coverage exempts you from purchasing the school's recommended insurance coverage.

1. Yes No Does your policy provided coverage for blood to blood occupational exposure

2. Yes No Does your policy allow access to primary care; (Physician Office Visits, Urgent, and Emergent Care) **Emergency only care is not comparable coverage**

3. Yes No Does your policy provide inpatient coverage of 80% of usual and customary reimbursement

4. Yes No Does your policy provide prescriptive medications

5. Yes No Does your policy provide inpatient and outpatient mental health benefits (including alcohol and substance abuse treatment)

6. Yes No Does your policy have an individual deductible less than $2500 per policy year

7. Yes No Is the insurance company licensed to do business in the State of Florida

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Birth Date of Policy Holder	ex: mm/dd/yyyy
Student First Name	
Student Last Name	
Email	
Student ID Number	
Campus Location	
Private Insurance Company Name	
Policy #	
Group #	
Insurance Company Phone #	Ex: XXXXXXXXXX
Name of Policy Holder	

By signing this form I am affirming that for the current academic year my private health insurance policy is adequate coverage as defined above (and if international also covers the items listed above). I hereby release Barry University, Inc., and its trustees, officers, employees, students, agents, and independent contractors of any responsibility for my health care and I will assume all financial responsibility for any medical expenses that I incur while attending Barry University. I understand that even though I have private insurance, I am eligible for the Barry University Student Health Plan and may enroll on a voluntary basis. (for more information on enrolling in the Barry Health Plan call 305-899-3750).

By signing this, I understand that the program reserves the right to request written confirmation of my benefits from my insurance company if my coverage is in question. Failure to comply with this request may: (1) disrupt my registration; and (2) result in an irrevocable billing of one (1) semester of the Primary Barry Health Plan.

Student Signature	
Date	ex: mm/dd/yyyy

Submission of this waiver does not automatically guarantee waiver acceptance. Students are notified via email if the waiver is not accepted.