

PART I - HEALTH HISTORY

Name _____
Last First Middle

Answer Yes or No. If the answer to any question below is yes, provide names and addresses of all physicians or healthcare providers who participated in the diagnosis, referral or treatment. Give details, reasons, and dates as appropriate. Please use additional space below or additional pages, if necessary.

A. Has your physical activity been restricted or your education interrupted for medical, surgical or psychiatric reasons during the past five years? Yes _____ No _____

B. Do you have any physical disabilities or handicaps? _____

C. Have you ever received treatment or counseling for a psychiatric condition, personality, character disorder or emotional problem?
Yes _____ No _____

D. Have you had any illness or injury which required treatment or hospitalization by a physician or surgeon?
Yes _____ No _____

E. List any medications you are taking regularly _____

F. Do you use drugs or substances that alter behavior? _____

G. List any allergies _____

H. Do you have any condition which requires special consideration or treatment? _____

I. Have you ever been denied medical or life insurance? If yes, provide details: _____

I declare that I have had no injury, illness or health condition other than specifically noted above and will notify St. George's University School of Medicine of any changes in my health status.

Date: _____ Signature: _____

PART III - IMMUNIZATION RECORD

Name _____
Last First Middle

Date of Birth _____ Social Security No. _____

Permanent Address _____
Number Street

City/Town State/Country Zip Code

To be completed and signed by a healthcare provider. All dates should include month and year. Include the manufacturer's name and lot number whenever possible.

A. EVIDENCE OF TUBERCULOSIS SCREENING COMPLETED 6 MONTHS PRIOR TO REGISTRATION:

1. TUBERCULOSIS SCREENING: Intermediate PPD (5TU Mantoux Test)

Date: _____ Product Name _____ Lot No: _____

Result: _____ mm. (Please indicate mm of induration)

PHYSICIAN/ REGISTERED NURSE SIGNATURE: _____

License #: _____ State/Country: _____

If your PPD is positive (> 10mm) now or by history, the following statement must be signed by a physician and submitted. Students with a history of BCG vaccination or anti-tuberculosis therapy are not excluded from this requirement.

2. I have been asked to evaluate the above named student because of a positive PPD. Based on the student's history, my physical exam and recent chest X-ray, I certify that the student is free of active tuberculosis and poses no risk to patients.

Physician Signature: _____ Date : _____

Print Name: _____

License # _____ State/Country: _____

B. MANDATORY REQUIREMENTS:

- 1.

Measles
Mumps
Rubella
Varicella

All students **must submit copies of laboratory results** of serum IgG antibody titers to measles, mumps, rubella (MMR) and varicella. Immunization records are **NOT** accepted as proof of immunity. Any laboratory results which indicate non-immunity require proof of additional vaccine administration.

- 2.

	<u>Date</u>	<u>Manufacturer & Lot #</u>	<u>Signature of Healthcare Provider</u>
Tdap (Adecel) booster within the last 10 years	_____	_____	_____

PART III - IMMUNIZATION RECORD

NAME _____

Last

First

Middle

3.

Hepatitis B

Documentation of three doses of hepatitis B vaccine, and a positive hepatitis B surface antibody titer are necessary. Alternatively, immunity may be documented by a positive hepatitis B core antibody. The hepatitis B vaccination is required for clinical training but is not required for registration at the University. If the hepatitis B vaccination has not been received prior to registration, it will need to be completed during the first two years of medical school. This must be followed with a serology for hepatitis B surface antibody.

	<u>Date</u>	<u>Manufacturer & Lot #</u>	<u>Signature of Healthcare Provider</u>
Hepatitis B			
Three immunizations at	1. _____	_____	_____
0, 1 month and 6 months	2. _____	_____	_____
	3. _____	_____	_____

AND

	<u>Date</u>	<u>Lab Result</u>	<u>Signature of Healthcare Provider</u>
Serum antibody titer			
(copy of Lab results must be submitted)	_____	_____	_____

	<u>Date</u>	<u>Manufacturer & Lot #</u>	<u>Signature of Healthcare Provider</u>
Booster (if necessary)	_____	_____	_____

4.

Meningococcal Meningitis Vaccine:

Information regarding this vaccine may be reviewed at www.cdc.gov/ncidod/dbmd/diseaseinfo.

Check one box and sign below:

I have read the information regarding meningococcal meningitis disease. I will obtain the vaccine against meningococcal meningitis within 30 days from my private health care provider.

I have read the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I will not obtain immunization against meningococcal meningitis disease.

I have had the meningococcal meningitis immunization (Menomune TM) within the past 5 years. Date received: _____

C. **RECOMMENDED IMMUNIZATIONS:**

Signature of Healthcare Provider

1. Polio

a. Completed primary series of polio immunizations

Dates: _____

	<u>Date</u>	<u>Manufacturer & Lot #</u>	<u>Signature of Healthcare Provider</u>
b. Booster			
Live vaccine (OPV)	_____	_____	_____
Inactivated (IPV)	_____	_____	_____

2. Hepatitis A

a. Two vaccinations at least 6 months apart.

1) _____

2) _____

or

	<u>Date</u>	<u>Lab Result</u>	<u>Signature of Healthcare Provider</u>
b. Positive serum antibody titer	_____	_____	_____

b. Positive serum antibody titer

PART III - IMMUNIZATION RECORD

ADDITIONAL IMMUNIZATIONS:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Student Signature _____ Date _____