

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 or 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:

Please see instructions on the front page. Check boxes where appropriate.

	<u>Date</u>	<u>Manufacturer & Lot #</u>	<u>Signature of Healthcare Provider</u>
1. Measles, mumps, rubella (MMR)			
a. Two immunizations at least	MMR#1 _____	_____	_____
30 days apart	MMR#2 _____	_____	_____
OR			
b. Serum antibody titer to MMR (copy of lab result must be Submitted)		<u>Results</u>	<u>Signature of Healthcare Provider</u>
	Measles IgG	_____	_____
	Mumps IgG	_____	_____
	Rubella IgG	_____	_____

2. Varicella: students may satisfy the requirement for varicella immunity by providing one of the following:
- A. Physician documentation of disease (i.e., history of "Chicken Pox")
 - B. Serum antibody titer to varicella showing immunity (**copy of lab result must be submitted**)
 - C. Immunization: proof of two varicella vaccines received at least 30 days apart

PART III - IMMUNIZATION RECORD (Continued)

ADDITIONAL IMMUNIZATIONS:

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

Date: _____ Signature: _____