American University of St. Vincent-School of Medicine
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HEALTH AND IMMUNIZATION

STUDENT INFORMATION					
Name			**Date**		
Address			**DOB**		**Age**
City		**State**	**Phone**		

MEDICAL HISTORY (To be completed by student)					
Tuberculosis or Hepatitis (Explain if Yes)	**Y**	**N**	Presently taking medication	**Y**	**N**
Fainting or dizziness while exercising	**Y**	**N**	History of head injury	**Y**	**N**
Allergies	**Y**	**N**	Past surgical procedures	**Y**	**N**
Asthma	**Y**	**N**	Any hospitalizations	**Y**	**N**
Bone/joint problems	**Y**	**N**	Any ongoing medical problems	**Y**	**N**
Seizures	**Y**	**N**	Significant past illness	**Y**	**N**

Student Agreement:

I have completed and/or verified the above section which requires me to list all previous injuries or additional conditions that are known to me which may affect my performance in representing my school and I verify that it is correct and complete. I further certify that the information in this form is complete and correct. I understand that the submission of false information is grounds for withdrawal of any offer of acceptance, cancellation of enrollment, and appropriate disciplinary action.

Student's Signature _____ Date _____

....EVERYTHING BELOW TO BE COMPLETED BY A PHYSICIAN....

PHYSICAL EXAMINATION

Height _____ Weight _____ Blood pressure _____ Pulse _____ LMP _____

I, _____, have examined _____ for admission into medical school. I do here by certify that the student is in good health and is not suffering from any communicable diseases. I also certify that I do not see any physical or mental impediment to the successful completion of his or her medical education.

IMMUNIZATION HISTORY (DT/Td within 10 years of exam date) (enter date, or ✓ if done today, or WS for "will schedule")

Immunizations

Rubella-1 dose
(or proof of immunity *rubella titre)* _____

Mumps-1 dose
(or proof of immunity *mumps mitre)* _____

Measles
(2 doses at least 1 month apart and after 12 months of age)
Date 1: _____
Date 1: _____

Has the student ever had Chickenpox? (circle) Y N

BCG Vaccine and Chest X-Ray(Non-US) _____

Labs

PPD Date and Results _____
(must be completed within the past year and updated annually) A Chest X-Ray is required if tested positive

Positive PPD Test Dates: _____

HIV(must be within 60 days of matriculation) _____

REQUIRED PRIOR TO CLINICAL PROGRAM

Hepatitis B Vaccine

Date 1: _____ Date 2: _____ Date 3: _____

HBSAB following series-Date and Results _____

Declination signed and on file date: _____

PHYSICIAN INFORMATION

Provider/Physician Signature : _____

Printed Name: _____ **Telephone Number:** _____

Facility Name: _____ **Fax Number:** _____

Facility Address: _____ **Facility City, State, Zip:** _____