International American University

HEALTH & IMMUNIZATION FORM

Directions: Please have your primary care provider complete this form. This form must be signed by the student and their primary care provider. Please note evidence of Mumps, Rubeola, Rubella (German measles) Varicella (chickenpox), Polio immunization is mandatory. Please also note for all MD program students Hepatitis B vaccination course must be completed prior to beginning clinical clerkships. All accepted students must submit the completed form to their New Student Coordinator.

LAST NAME | FIRST NAME | MIDDLE INITIAL

ADDRESS

CITY/TOWN | PROVINCE/STATE | POSTAL/ZIP CODE | COUNTRY

CITIZENSHIP | PRIMARY TELEPHONE# | CELLULAR/MOBILE #

DATE OF BIRTH | SSN/SIN (US & CANADA STUDENTS) | PASSPORT NUMBER (NON-US & CANADA STUDENTS)

PAST MEDICAL AND SURGICAL HISTORY (Please note all hospital admissions within last 5 years, and use additional sheets if necessary)

____

____

____

____

Has the student suffered from physical or mental illness in the past year (please circle)? YES NO
If yes, please state all medications here:

____

____

____

Does the student suffer from any allergies (please circle)? YES NO
If yes, please give account here:

____

____

____

Height: ________ Weight: ________ Nose: ________ Throat: ________ Ears: ________

Eyes: (w/out glasses) Rt ________ LT ________ Eyes (w/glasses) Rt ________ Lt ________

Temp: ________ Pulse: ________ Resp: ________ B/P: ________ Lungs: ________

Heart: ________ Neuro: ________ Extremities: ________ Abdomen: ________ Gu/Gyn: ________

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PPD/Mantoux (TB) Test: Date: ____________ Result: ____________
If positive PPD, did you find any evidence of disease? ____________ Chest X-Ray Date: ____________
Interpretation: ____________ Prophylactic Rx: ____________

Tetanus (within ten years): ________ VDRL (mandatory): ________ Mumps (Titer): ________ Varicella (Chickenpox) Titer: ________

Rubella (German measles) Titer: ________ Date: ________ Rubeola (measles) Titer: ________ Date: ________

Those with negative Varicella Titer need proof of immunization/dates of Viravax: ________ Polio immunization/Titer: ________ Date: ________

Hepatitis B Vaccine Dates (Mandatory, Course must be completed before beginning clinical clerkships):

Date I: ________ Date II: ________ Date III: ________ If there is any reason why immunization cannot be given, please specify in writing below:

____

Urine Test result for “Routine Drug Screening”(interpretation by primary care provider): ____________

PHYSICAL EXAMINATION DECLARATION *(To be completed by a physician or primary care provider)*

I, __________________________ have given a complete examination to ______________________________and in my opinion he/she is in ________________ physical and mental and is capable of participating without hazard in clinical practice settings.

____
Physician or Primary Care Provider Signature Address

____
Phone License# and State/Country of Licensure

STUDENT DECLARATION *(To be completed by the accepted student)*
I, the undersigned, give my permission to have my medical records released to the affiliating agency as requested. I also verify that health and evacuation insurance is up to date and current.

____
Student Signature Date