

MEDICAL UNIVERSITY OF THE AMERICAS

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***** Titer Lab Report(s) must be attached! *****

STUDENT PHYSICAL EXAMINATION AND IMMUNIZATION FORM

Student Name: _____ Date of Birth: ____/____/____
Last *First*

Address: _____ Telephone No.: _____

	Titer Date	Result: Positive (Immune / Negative)	If negative titer: Re-immunization date
Rubella:	____/____/____	_____	____/____/____
Rubeola (Measles):	____/____/____	_____	____/____/____
Mumps:	____/____/____	_____	____/____/____
Varicella:	____/____/____	_____	____/____/____
Hepatitis B surface AB:	____/____/____	_____	____/____/____

(1st and 2nd dose must be administered before traveling to the island)

2. **HIV Test:** Date: ____/____/____ **(LAB REPORT MUST BE ATTACHED)**

3. **Polio:** oral injection Dates: ____/____/____ ____/____/____ ____/____/____ ____/____/____

4. **Tetanus-Diphtheria:** Date: ____/____/____ **(most recent - must be within 10 years)** Update: ____/____/____

5. **Tuberculosis:** TST/PPD (Mantoux) Date: ____/____/____ Negative Positive: _____mm reading
 Repeat Application: Date: ____/____/____ Negative Positive: _____mm reading

If (1) positive PPD, or (2) history of positive PPD, or (3) history of BCG vaccination, indicate the date/results of the most recent chest x-ray and whether any therapy has been initiated/completed

CXR: ____/____/____ Negative Positive **(provide a copy of the radiology report regardless of results)**

Comments: _____

6. Does the student have any physical disabilities?
 No Yes: *explain* _____

7. Does the student have any medical condition(s) or learning disabilities requiring special attention during medical school?
 No Yes: *explain* _____

8. Is the student presently taking any form of medication prescribed by a physician?
 No Yes: *list* _____

Physical Examination:

I have performed and recorded a medical history and physical examination of the above named student, which failed to reveal any health impairment which may be of potential risk to patients or which might interfere with the performance of his/her duties, and failed to demonstrate any habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which alter mood or behavior.

NAME OF PHYSICIAN ADDRESS

SIGNATURE DATE