MEDICAL UNIVERSITY OF THE AMERICAS

Please return this form to:
MUA Clinical Department
c/o R3 Education Inc.
27 Jackson Rd., Suite 302
Devens, MA 01434

Phone: 978-862-9500
Fax: 978-862-9599

Titer Lab Report must be attached

STUDENT PHYSICAL EXAMINATION AND IMMUNIZATION FORM

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

Address: _____ Telephone No.: _____

1. The following Immunities are verified by **BLOOD TITER: (*Titer Lab Report must be attached*)**

	Immunization Dates	TITER Date & Result (Positive or Negative)	If negative titer, Re-immunization date
Rubella (German Measles):	___/___/___	_____	___/___/___
Rubeola (Measles):	___/___/___; ___/___/___	_____	___/___/___
Mumps:	___/___/___	_____	___/___/___
Varicella:	___/___/___	_____	___/___/___

Hep B ***Hep B Surface Antibody Results***

Hepatitis B Series Dates: ___/___/___; ___/___/___; ___/___/___ _____

**********First and second doses must be administered before traveling to the island.*********

(Titer MUST be drawn at least 4 weeks after completion of series. If titer is negative, student must have additional immunizations)

For individuals having direct patient contact or any possibility of contact with blood or body fluids, Hepatitis series administration or signed declination are required.

2. Tuberculosis: PPD (Mantoux) Date: ___/___/___ (Updates) ___/___/___ ___/___/___

☐ **Negative** ☐ **Positive** _____**mm reading** _____**mm reading** _____**mm reading**

(If positive, please indicate the date and results of the most recent chest x-ray and whether or not any therapy has been initiated) ___/___/___ _____

3. Tetanus-Diphtheria Dates: ___/___/___ ***(Most recent – Must be within 10 years)*** (Updates) ___/___/___

4. Does student have any physical disabilities? ☐ No ☐ Yes
If yes, please explain_____

5. Does the student have any medical condition(s) or learning disability that may require special attention during medical school? ☐ No ☐ Yes
If yes, please explain:_____

6. Is the student presently taking any form of medication prescribed by a physician? ☐ No ☐ Yes
If yes, please list the medications:_____

_____

Physical Examination:

I have performed and recorded a physical examination and the medical history 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 nor any habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which alter mood or behavior.

_____	_____	_____	_____
Signature of Physician	Print Name	Address	Date