Student Health Record 2020

Student's Name: ______________________________________ **DOB:** ___________
Student's Address: ____________________________________ **Phone Number:** ______________
____

1. **Physical Exam**: Please note only **abnormal** findings within each system. The student will not be permitted to begin clinical without all information completed on this form and applicable test results sent and vaccination information included.

SENSES:
Vision ____
____
Hearing____
____
Taste ____
____
Smell ____
____
SYSTEMS:
Integumentary____
____

Neurological/Sensory____
____

Cardiovascular____
____

Respiratory____
____

Genitourinary____
____

Reproductive____
____

Gastrointestinal____
____

Musculoskeletal____
____

Endocrine/Metabolic____
____

<u>PLEASE ATTACH VERIFICATION AND RESULTS</u> FOR THE FOLLOWING TESTS (REQUIRED):

1. **PPD: Date Placed: ________ Date Read: _________ Result:_____________**

2. **Urinalysis (Copy of results must be included with form)**

3. **CBC and Differential (Copy of results must be included with form)**

4. **Vaccination Record OR titers for the following:**
   - **MMR (Measles, Mumps, Rubella)**
   - **Varicella**
   - **MUMPS TITER- now required by various clinical sites in addition to proof of MMR**

****Must have proof of all vaccinations that is within the last 10 years or must have adequate titer verification.**

****If titer levels inadequate, submit documentation regarding re-vaccination.**

****If student chooses to re-vaccinate and defer drawing of titers, submit documentation regarding re-vaccination.**

5. Verification of Tetanus within the last 10 years

6. Verification of Polio (IPV) Vaccine/Oral

7. Verification of the Hepatitis Series: #1 Date________#2 Date________#3 Date__________

8. List Current Prescription Medications:____
____
____
____
____

Physician/Nurse Practitioner Signature__________________________ Exam Date________

Physician's Office Address: __________________________________
____
____
____

Physician's Office
Phone Number ______________________________
Fax Number ______________________________

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