

HEALTH RECORD FORM/IMMUNIZATIONS

This form must be completed and be current in order for you to be accepted into a hospital or clinic environment. It is likely that you submitted this form upon application but it may now be two years old and needs to be updated. In particular, students are asked to be sure to have completed the Hepatitis B series of three injections and need to have a current 2-step PPD test.

INSTRUCTIONS: Make a copy of the completed form for your own record and send the original directly to:
University of Sint Eustatius School of Medicine – 6901 Jericho Turnpike, Suite 215, Syosset New York, 11791.

PERSONAL DATA

NAME:

Last

First

Middle

SS #/SIN #: - -

DATE OF BIRTH: / /
 MM DD YY

SEX: M F
 Circle One

PERMANENT ADDRESS:

CITY: _____ **STATE/PROVINCE:** _____ **ZIP/POSTAL CODE:** _____

TELEPHONE: () _____ **EMAIL:** _____

NEXT OF KIN

NAME OF KIN: _____ **RELATIONSHIP:** _____

Last

First

ADDRESS: _____

CITY: _____ **STATE/PROVINCE:** _____ **ZIP/POSTAL CODE:** _____

TELEPHONE: () _____ **EMAIL:** _____

In Case of Emergency Notify:

NAME: _____ **RELATIONSHIP:** _____

Last

First

TELEPHONE: () _____ **EMAIL:** _____

HEALTH CARE

NAME OF PRIMARY CARE PROVIDER: _____ **ADDRESS:** _____

CITY: _____ **STATE/PROVINCE:** _____ **ZIP/POSTAL CODE:** _____

TELEPHONE: () _____ **EMAIL:** _____

HEALTH INSURANCE COMPANY _____ **POLICY No.:** _____

NAME OF CONTACT PERSON: _____ **TELEPHONE:** () _____

HEALTH HISTORY

1. Check boxes to indicate whether you have (or had in past) these problems. Provide details of positive answers on the bottom of this sheet. We may request that you have your health care provider send further information after we review your answers.

	Yes	No	Date	Condition
1	<input type="checkbox"/>	<input type="checkbox"/>		Anemia (including Sickle Cell Anemia)
2	<input type="checkbox"/>	<input type="checkbox"/>		Asthma
3	<input type="checkbox"/>	<input type="checkbox"/>		Bleeding Disorder
4	<input type="checkbox"/>	<input type="checkbox"/>		Blindness (complete or partial)
5	<input type="checkbox"/>	<input type="checkbox"/>		Cancer (including Leukemia, Hodgkin's Disease)
6	<input type="checkbox"/>	<input type="checkbox"/>		Colitis, Ulcerative
7	<input type="checkbox"/>	<input type="checkbox"/>		Cystic Fibrosis
8	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes (if yes specify)
9	<input type="checkbox"/>	<input type="checkbox"/>		Epilepsy or other Seizure Disorder
10	<input type="checkbox"/>	<input type="checkbox"/>		Glaucoma
11	<input type="checkbox"/>	<input type="checkbox"/>		Hearing Loss (complete or partial)
12	<input type="checkbox"/>	<input type="checkbox"/>		Heart Enlarged
13	<input type="checkbox"/>	<input type="checkbox"/>		Heart Murmur
14	<input type="checkbox"/>	<input type="checkbox"/>		Heart Valve Problem
15	<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis
16	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure
17	<input type="checkbox"/>	<input type="checkbox"/>		Hypoglycemia
18	<input type="checkbox"/>	<input type="checkbox"/>		Infectious Mononucleosis in past 6 months
19	<input type="checkbox"/>	<input type="checkbox"/>		Inflammatory Bowel Disease
20	<input type="checkbox"/>	<input type="checkbox"/>		Kidney Infection or Stone
21	<input type="checkbox"/>	<input type="checkbox"/>		Migraine Headache
22	<input type="checkbox"/>	<input type="checkbox"/>		Pneumonia
23	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatic Fever
24	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatoid Arthritis
25	<input type="checkbox"/>	<input type="checkbox"/>		Stomach Ulcers
26	<input type="checkbox"/>	<input type="checkbox"/>		Substance Abuse (Alcohol and/or Drugs)
27	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid Problems
28	<input type="checkbox"/>	<input type="checkbox"/>		Tuberculosis
29	<input type="checkbox"/>	<input type="checkbox"/>		Emotional/Psychiatric Problems
30	<input type="checkbox"/>	Other	(Describe):	
Explain:				

Name _____ Date of Birth _____ / _____ / _____
Last First Middle MM DD YY

2. Name any illness or health condition for which you are CURRENTLY under treatment:

3. If you have been hospitalized within the past 5 years:

Date Name & Address of Hospital Name of Physician Diagnosis

Date	Name & Address of Hospital	Name of Physician	Diagnosis

4. List any medicine, food, or environmental substance to which you are ALLERGIC:

CURRENT HEALTH INFORMATION

5. List any medications you are now taking. (Include drug name, dose and reason for taking the drug):

6. Limitations and Disabilities: Check one box:

YES **NO** Limitations to physical activity:

 If yes, specify details:

 Learning challenges:

If yes, specify details:

 Special accommodations needed for assistance:

If yes, documentation must be provided by Primary Care Provider:

(TINE Test is not acceptable)

Name _____ Date of Birth _____ / _____ / _____
Last First Middle MM DD YY

7. TUBERCULOSIS SCREENING (Required)

8. TWO STEP PPD SKIN TESTING:

The Occupational Health and Safety Administration (OSHA, 1994) requires that a 2-step baseline be performed on students/health care workers who have not had a documented negative skin test result during the preceding 12 months.

7 TO 10 DAY PROCESS:

2-Step Testing may be accomplished by placing the first test on day one, reading within 48-72 hours. If read as negative, **the second test** may be placed *within 7- 10 days after* the first is read. The second test is read within 48-72 hours.

PPD RESULTS:

1st Step: Site:	Placed By:
Date Planted:	Date Read:
Brand/Lot Number	PPD Skin Test (circle one): Negative Positive
Measurement of induration:	Read by (Please Print):
State / License Number:	Signature:

2nd Step: Site:	Placed By:
Date Planted:	Date Read:
Brand/Lot Number	PPD Skin Test (circle one): Negative Positive
Measurement of induration:	Read by (Please Print):
State / License Number:	Signature:

Chest x-ray: Students reporting **history** of a previously (documented) positive PPD skin test are not required to have a PPD test repeated. **A chest x-ray will be required** unless documentation of a negative chest x-ray (within the past 12 months) is available. If chest x-ray is negative, a repeat chest x-ray is required in 2-5 years or if symptoms develop that could be attributed to tuberculosis. **A copy of the radiologist report of the chest x-ray must be submitted with this health form.**

Chest x-ray (circle one): Negative Positiv	Date of x-ray:
Physician Signature:	Print Physicians Name:
State/License:	Date:

CERTIFICATE OF IMMUNIZATION*

Name _____ Date of Birth _____ / _____ / _____
Last First Middle MM DD YY

Diphtheria Tetanus Pertussis			
1.	/ /	2.	/ /
	<i>mm / dd / yyyy</i>		<i>mm / dd / yyyy</i>
3.	/ /	4.	/ /
	<i>mm / dd / yyyy</i>		<i>mm / dd / yyyy</i>
Diphtheria Tetanus (Td)			
1.	/ /	2.	/ /
	<i>mm / dd / yyyy</i>		<i>mm / dd / yyyy</i>
3.	/ /		
	<i>mm / dd / yyyy</i>		
Diphtheria / Tetanus Booster (Booster must be given within 10 years)			
1.	/ /	2.	/ /
	<i>mm / dd / yyyy</i>		<i>mm / dd / yyyy</i>
3.	/ /		
	<i>mm / dd / yyyy</i>		
Poliomyelitis (opv)			
1.	/ /	2.	/ /
	<i>mm / dd / yyyy</i>		<i>mm / dd / yyyy</i>
3.	/ /	4.	/ /
	<i>mm / dd / yyyy</i>		<i>mm / dd / yyyy</i>
Hepatitis B Vaccine			
1.	/ /	2.	/ /
	<i>mm / dd / yyyy</i>		<i>mm / dd / yyyy</i>
3.	/ /		
	<i>mm / dd / yyyy</i>		
Live Virus Vaccine Or, Serological Confirmation of Immunity			
1.	/ /		
	<i>mm / dd / yyyy</i>		
MMR (Measles, Mumps, Rubella): (Two immunizations required if born after 1957)			
1.	/ /	2.	/ /
	<i>mm / dd / yyyy</i>		<i>mm / dd / yyyy</i>
Varicella Zoster: Or, Serological Confirmation of Immunity			
1.	/ /		
	<i>mm / dd / yyyy</i>		

Licensed Health Professional Signature:	
Licensed Health Professional Printed Name	
Name of Medical Facility:	
State of licensure:	License Number:
Address:	
City:	State/Province:
	Zip/Postal Code:
Phone:	
Fax:	Date:

Name _____ Date of Birth _____ / _____ / _____
Last First Middle MM DD YY

PHYSICAL EXAMINATION (to be completed by primary Physician) Date of Exam _____

1. HEIGHT _____ WEIGHT _____

2. BLOOD PRESSURE _____ PULSE _____ RESP _____ TEMP _____

3. Please indicate any abnormalities in the following and describe findings at right:

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	Heart
<input type="checkbox"/>	<input type="checkbox"/>	Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	Lymph	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	Eyes/Vision	<input type="checkbox"/>	<input type="checkbox"/>	Genitals
<input type="checkbox"/>	<input type="checkbox"/>	Ears/Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Neurological
<input type="checkbox"/>	<input type="checkbox"/>	Nose/Smell	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health
<input type="checkbox"/>	<input type="checkbox"/>	Mouth/Throat	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Stability
<input type="checkbox"/>	<input type="checkbox"/>	Neck/Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Breasts
<input type="checkbox"/>	<input type="checkbox"/>	Other _____			

4. Do you recommend any limitations to physical activities? Yes No

If yes, specify in detail:

5. In your professional opinion, do you think this student has an adequate state of physical and mental health to function as a Medical student: Yes No

If no, specify in detail:

6. General Comments:

Your signature below indicates that you have reviewed this entire document

Examiners Signature:		
Examiners Printed Name		
Name of Medical Facility:		
State of licensure:		License Number:
Address:		
City:	State/Province:	Zip/Postal Code:
Phone:		
Fax:	Date:	