



St. George's University

SCHOOL OF MEDICINE

THINK BEYOND

August _____ January _____ May _____ Year _____

MD _____ MPH/MSc _____ Nursing _____ Premedical _____ Charter Foundation _____

Part I

A. PERSONAL INFORMATION

Name (Print) _____ ID A00 _____
Last First Middle

Date of Birth _____ Social Security No. _____

Male _____ Female _____

Home Phone No. _____ Cell Phone No. _____

Home Address _____
Number Street

City/Town State/Country Zip Code

Person to be notified in case of emergency:

Name Relationship

Home Phone No. _____ Business Phone No. _____

Cell Phone No. _____

Address _____
Number Street

City/Town State/Country Zip Code

Part I

B. HEALTH HISTORY

Name (Print) _____
Last First Middle

Answer Yes or No to all questions below. IF the answer to any question below is yes, provide names and addresses of all physicians or health care providers who participated in the diagnosis, referral, or treatment. Give details, reasons, and dates as appropriate. Please use additional space below or additional pages, if necessary.

A. Has your physical actively been restricted or your education interrupted for medical, surgical, or psychiatric reasons during the past three years? YES _____ NO _____

B. Do you have any physical disabilities or handicaps? YES _____ NO _____

C. Have you ever received treatment or counseling for a psychiatric condition, personality or character disorder, or emotional problem? YES _____ NO _____

D. Have you had any illness or injury which required treatment or hospitalization by a physician or surgeon? YES _____ NO _____

Part I

B. HEALTH HISTORY (continued)

E. List any medications you are taking regularly.

F. Do you use drugs or substances that alter your behavior? YES _____ NO _____

G. List any allergies and allergic reactions.

H. Do you have any condition which requires special consideration or treatment? YES _____ NO _____

Part I

B. HEALTH HISTORY (continued)

Please indicate if you have had any of the following in the past 12 months:

	YES	NO		YES	NO
Cough			Sore Throat		
Fever			Skin Infection		
Night Sweats			Rash		
Weigh Loss			Nausea		
Shortness of Breath			Vomiting		
Hemoptysis			Diarrhea		

If yes to any of the above, please explain details and current status:

I declare that I have had no injury, illness, or health condition other than specifically noted above and will notify St. George's University School of Medicine of any changes to my health status.

Date: _____ Signature: _____

Part III - TB SCREENING AND IMMUNIZATION RECORD

Name (Print) _____ ID A00 _____
Last First Middle

Date of Birth _____ Social Security No. _____

Permanent Address _____
Number Street

City/Town State/Country Zip Code

To be completed and signed by a health care provider. All dates should include month and year. Include the manufacturer's name and lot number whenever possible.

A. MANDATORY TB SCREENING:

To be completed and signed by a health care provider. All dates should include month and year. Include the manufacturer's name and lot number whenever possible. Please submit evidence of tuberculosis screening completed within six months prior to registration. We accept the Mantoux skin test (PPD) or the QuantiFERON blood test. The PPD must be indicated in millimeters. Students with a history of BCG vaccination or anti-tuberculosis therapy are not excluded from this requirement.

1. Intermediate PPD (5TU Mantoux Test)

Date _____ Product Name _____ Lot No. _____

Result _____ mm. (Please indicate mm of induration)

PHYSICIAN / REGISTERED NURSE SIGNATURE _____

License No. _____ State/Country _____

If your QuantiFERON test or PPD is positive (> 10mm) now or by history, you need not repeat these. In this case, the following statement must be signed and dated by a physician and submitted along with the official report of a recent chest x-ray. The exam and the chest x-ray must be done within three months prior to registration date.

"I have been asked to evaluate the above named student because of a positive PPD. Based on the student's history, my physical exam and recent chest X-ray (date _____), I certify that the student is free of active tuberculosis and poses no risk to patients."

PHYSICIAN / REGISTERED NURSE SIGNATURE _____

Physician's / Registered Nurse Name (Please print) _____

License No. _____ Date _____ State/Country _____

Part III - TB SCREENING AND IMMUNIZATION RECORD (continued)

B. MANDATORY REQUIREMENTS

1. Measles, Mumps, Rubella, Varicella:

All students must submit copies of laboratory results of serum IgG antibody titers to measles, mumps, rubella (MMR) and varicella. Immunization records are NOT accepted as proof of immunity. Any laboratory results which indicate non-immunity require proof of additional vaccine administration.

2. Tdap (Adecel) booster within the last 10 years:

Date _____ Manufacturer and Lot No. _____

Signature of Health Care Provider _____

3. Hepatitis B

Documentation of three doses of hepatitis B vaccine, and a positive hepatitis B surface antibody titer are necessary. Alternatively, immunity may be documented by a positive hepatitis B core antibody. The hepatitis B vaccination is required for clinical training but is not required for registration at the University. If the hepatitis B vaccination has not been received prior to registration, it will need to be completed during the first two years of medical school. This must be followed with a serology for hepatitis B surface antibody.

Hepatitis B: Three immunizations at 0, 1 month, and 6 months:

Date _____ Manufacturer and Lot No. _____

Signature of Health Care Provider _____

Date _____ Manufacturer and Lot No. _____

Signature of Health Care Provider _____

Date _____ Manufacturer and Lot No. _____

Signature of Health Care Provider _____

AND

Serum Antibody Titer (Copy of Lab Results must be submitted)

Date _____ Manufacturer and Lot No. _____

Signature of Health Care Provider _____

Booster (if necessary)

Date _____ Manufacturer and Lot No. _____

Signature of Health Care Provider _____

Part III - TB SCREENING AND IMMUNIZATION RECORD (continued)

4. Meningococcal Meningitis Vaccine:

Information regarding this vaccine may be reviewed at www.cdc.gov/ncidod/dbmd/diseaseinfo

Check one box and sign below:

I have read the information regarding meningococcal meningitis disease. I will obtain the vaccine against meningococcal meningitis within 30 days from my private health care provider.

I have read the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I will not obtain immunization against meningococcal meningitis disease.

I have had the meningococcal meningitis immunization (Menomune TM) within the past 5 years.

Date Received _____ Signature of Health Care Provider _____

C. RECOMMENDED IMMUNIZATIONS

1. Polio

a. Completed primary series of polio immunizations:

Dates _____

b. Booster

Live Vaccination (OPV)

Date _____ Manufacturer and Lot No. _____

Signature of Health Care Provider _____

Inactivated (IPV)

Date _____ Manufacturer and Lot No. _____

Signature of Health Care Provider _____

2. Hepatitis A

a. Two vaccinations at least six months apart:

Date _____ Manufacturer and Lot No. _____

Signature of Health Care Provider _____

Date _____ Manufacturer and Lot No. _____

Signature of Health Care Provider _____

b. Positive serum antibody titer:

Date _____ Manufacturer and Lot No. _____

Signature of Health Care Provider _____

Part III - TB SCREENING AND IMMUNIZATION RECORD (continued)

ADDITIONAL IMMUNIZATIONS

Student Signature _____ Date _____