HEALTH HISTORY
(To be Completed by Student)

DO YOU HAVE: YES NO YES NO
Alcohol/drug Dependency ( ) ( ) G.I. Problems ( ) ( )
Allergic Reaction ( ) ( ) Joint Disease ( ) ( )
Asthma ( ) ( ) Kidney Disease ( ) ( )
Diabetes ( ) ( ) Rheumatic Fever ( ) ( )
Difficulty with Coordination ( ) ( ) Seizure disorder ( ) ( )
Emotional Disorder ( ) ( ) Severe Hearing Loss ( ) ( )
Heart Disease ( ) ( ) Vision that cannot be corrected with glasses ( ) ( )
Any back problems ( ) ( ) Tuberculosis ( ) ( )
Surgery within the last year: ( ) ( )
Hospitalization within the past 5 years? ( ) ( )
Do you take any medications on a regular basis? ( ) ( )
Other ___________________________

Please explain all YES answers.
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Students in the above programs are required to have this Confidential Health Certificate completed, their immunizations up to date, and all forms handed into the Health Services Office BEFORE any clinical experience. Fall semester deadline August 10th; Spring semester January 15th. Therefore, please sign below to indicate your permission for this form to be released to the Health Services Office, the Department of Health Sciences/Allied Health, and any designated clinical site(s) required for your education.

Signature of Student_____________________________ Date____________________________

Note: Students in ALL programs are to submit this form and copies of all required documents to Student Health Services Office. In addition, students in the NURSING programs are to submit one set of copies of this health certificate and all required documents to their clinical instructor on the first day of class.
A. Required Mantoux PPD – must be done annually unless previously positive

Date given __________ Date read __________ Result ________ ________ 
Mantoux PPD must be read within 48-72 hours of administration. MD Signature

For Positive Mantoux PPD or previous severe reaction, Chest X-ray is required every other year (submit radiological report)

Date ________________ Result ________________________________

B. Required Hepatitis B – Satisfy either (1), or (2), or (3) below:

1. Three (3) doses of vaccine. First two doses must be 30 days apart and completed before classes begin. Third dose should be given 6 months after first dose.

   1st Date: _____________ 2nd Date: _______________ 3rd Date: _______________

   OR

2. Titre results showing immunity (attach copy of lab report).

   Date of Titre _______________ Result ____________________________

   OR (If negative, complete 1 or 3)

3. Signed waiver to accompany this form. (Waivers can be obtained at the Health Services office).

C. Required IGG Titres (attach copy of lab report)*

   Measles (IGG) __________ Mumps (IGG) __________ Rubella (IGG) __________ Varicella (IGG) __________

   Date Date Date Date

   *All negative or equivocal titer results require immunization and a repeat titer. (This means that if the titer is not positive, you must receive the corresponding immunization(s) and a repeat titre 2-3 months after re-immunization.)

D. Required Tetanus/Diphtheria Immunization within 10 Years

   Name of Immunization ________________________ Date __________________________

E. Physical Examination – must be done annually (ALL AREAS MUST BE COMPLETED)

   Height _________ Weight _________ Skin ______________________________
   Ears R______ L______ Lymph Nodes __________________
   Vision (with glasses) R______ L______ Nose __________________
   Teeth _____________________ Throat __________________
   Thyroid _____________________ Lungs __________________
   Blood Pressure __________________ Heart __________________
   Abdomen __________________ Hernia __________________
   Neurological Exam __________________
   Extremities __________________
   Previous Psychiatric Treatment __________________

F. Health Care Provider’s Statement:
   “I performed the above medical evaluation and found, to the best of my knowledge, him/her to be free from physical or mental impairments including habituation or addiction to depressants, stimulants, narcotics, alcohol, or other behavior-altering substances which might interfere with the performance of his/her duties or would impose potential risk to patients or personnel. The following active problems were identified, which might interfere with the performance of his/her duties.”

   __________________________________________________________________________

   Health Care Provider’s Signature

   Date __________ Phone Number ________________________________

   Form will not be accepted without Physicians Stamp