

# Marshall University Joan C. Edwards School of Medicine

**Please return this form to:**

Amy Smith, BSN  
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**\*\*Completed physical form and all required blood titer value reports must be received before July 1)\*\***

## STUDENT PHYSICAL EXAMINATION AND IMMUNIZATION FORM

Student Name: \_\_\_\_\_  
**LAST**
**FIRST**

Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Telephone No. \_\_\_\_\_  
Email Address: \_\_\_\_\_

1. The following immunities are verified by	<b>BLOOD TITER: (IgG Lab Values must be attached)</b>	
<b>Immunization Dates</b>	<b>TITER Date &amp; Result (Positive or Negative)</b>	<b>If negative titer, Reimmunization date</b>
Rubella (German Measles): ____/____/____; ____/____/____	_____	____/____/____
Rubeola (Measles): ____/____/____; ____/____/____	_____	____/____/____
Mumps: ____/____/____; ____/____/____	_____	____/____/____
Varicella(Chicken Pox): ____/____/____; ____/____/____	_____	____/____/____
<b>HEB B</b>		
<b>Hepatitis B Series Dates:</b> ____/____/____; ____/____/____; ____/____/____		<i>Hep. B Surface Antibody Results</i>
(Titer MUST be drawn after completion of series. If negative titer, student must have additional immunizations)		

2. **Tuberculosis:** PPD (Mantoux) (Tine not accepted) Date \_\_\_\_/\_\_\_\_/\_\_\_\_ **(Most recent must be after Jan. 2012)**  
 **Negative**     **Positive** **(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. **Immunizations:**

Tetanus-Diphtheria    Dates \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_/\_\_\_\_/\_\_\_\_    **Tdap** \_\_\_\_\_ Date \_\_\_\_\_  
*(If most recent Td > than 2 years Tdap required)*

Polio **(min. 3 required)**    Dates \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_/\_\_\_\_/\_\_\_\_ **(Date of last immunization)**

**If there is a contraindication to a required immunization please document reason.**

4. Does this student have any acute or chronic health problems?     No     Yes  
 If yes, please explain: \_\_\_\_\_

5. Is this student at high risk for a treatable condition (e.g., hypertension, diabetes, and hypercholesterolemia)?  
 No     Yes    If yes, please explain: \_\_\_\_\_

Physical Examination: (For matriculating students only)

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