



Last Name:	First Name:	MI:
DOB:	Last 4 SS#:	
Street Address:		
City:	State:	
Zip Code:	Phone Number:	

Email Address:

MMR (Measles, Mumps, Rubella) – 2 doses of MMR vaccine, and serologic proof of immunity for Measles, Mumps and Rubella.

	Vaccine/Titer	Date	
MMR 2 Doses of MMR Vaccine	MMR Dose #1		
	MMR Dose #2		
Measles	<i>Serologic Immunity (IgG antibodies titer)</i>		<input type="checkbox"/> <i>Copy Attached</i>
Mumps	<i>Serologic Immunity (IgG antibodies titer)</i>		<input type="checkbox"/> <i>Copy Attached</i>
Rubella	<i>Serologic Immunity (IgG antibodies titer)</i>		<input type="checkbox"/> <i>Copy Attached</i>

Hepatitis B Vaccination-3 doses of vaccine followed by a **QUANTITATIVE Hepatitis B Surface Antibody Titer**. If negative, complete a second Hepatitis B series followed by a repeat titer. If Hepatitis B Surface Antibody is negative after a second series, additional testing including Hepatitis B Surface Antigen testing should be performed.

Primary Hepatitis B Series	<i>Hepatitis B Vaccine Dose #1</i>		Result _____ ml/ml <input type="checkbox"/> <i>Copy Attached</i>
	<i>Hepatitis B Vaccine Dose #2</i>		
	<i>Hepatitis B Vaccine Dose #3</i>		
	QUANTITATIVE Hep B Surface Antibody		
Secondary Hepatitis B Series	<i>Hepatitis B Vaccine Dose #4</i>		
	<i>Hepatitis B Vaccine Dose #5</i>		
	<i>Hepatitis B Vaccine Dose #6</i>		
	QUANTITATIVE Hep B Surface Antibody		
Hepatitis B Vaccine Non-Responder <i>(If Hep B Surface Antibody Negative after primary and secondary series)</i>	<i>Hepatitis B Surface Antigen (if 2nd titer negative)</i>		<input type="checkbox"/> <i>Copy Attached</i>
	<i>Hep B Core Antibody (if 2nd titer negative)</i>		<input type="checkbox"/> <i>Copy Attached</i>
Chronic Active Hepatitis B	<i>Hep B Surface Antigen</i>		<input type="checkbox"/> <i>Copy Attached</i>
	<i>Hep B Viral Load</i>		<input type="checkbox"/> <i>Copy Attached</i>

Additional Comments:

Varicella (Chicken Pox) – 2 Doses of vaccine and positive serology, or positive serology only

	Date		
	<i>Varicella Vaccine #1</i>		
	<i>Varicella Vaccine #2</i>		
	<i>Serologic Immunity (IgG antibodies titer)</i>		<input type="checkbox"/> Copy Attached

Tetanus-diphtheria-pertussis – One dose of adult Tdap within the last 10 years

	<i>Vaccine</i>	<i>Date</i>	
	<i>Tdap Vaccine (Adacel, Boostrix, etc.)</i>		<input type="checkbox"/> Copy Attached

Influenza vaccine – One dose annually, each fall.

	<i>Vaccine</i>	<i>Date</i>	
	<i>Flu Vaccine</i>		<input type="checkbox"/> Copy Attached

TUBERCULOSIS SCREENING- Results of last 2 TST's (PPDs) or 1 IGRA blood test are required regardless of prior BCG status. If you have a history of a positive TST >10mm or IGRA, please provide information regarding an evaluation and/or treatment below. You only need to complete one section. Most recent test must be after January, 2019.

Section A <i>Negative Skin or Blood Test History</i>		<i>Date Placed</i>	<i>Date Read</i>	<i>Reading</i>	<i>Interpretation</i>
	<i>TST #1</i>			mm	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	<i>TST #2</i>			mm	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	<i>TST #3</i>			mm	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
				Result	
	<i>IGRA Blood Test</i>			<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> Copy Attached

Section B <i>History of Latent Tuberculosis, Positive Skin Test, or Positive Blood Test</i>		<i>Date Placed</i>	<i>Date Read</i>	<i>Reading</i>	<i>Interpretation</i>
	<i>Positive TST</i>			_____ mm	
				Result	
	<i>Date of Positive IGRA</i>			_____ IU	<input type="checkbox"/> Copy Attached
	<i>Date of Chest X-Ray</i>				<input type="checkbox"/> Copy Attached
	<i>Prophylactic Medications for latent T B taken?</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>Total Duration of prophylaxis</i>				_____ Months

Section C <i>History of Active Tuberculosis</i>					
	<i>Date of Diagnosis</i>				
	<i>Date Treatment was Completed</i>				<input type="checkbox"/> Copy Attached
	<i>Date of Last Annual CXR</i>				<input type="checkbox"/> Copy Attached

Additional Comments:

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HISTORY AND PHYSICAL EXAMINATION

HT: _____ WT: _____ BP: _____ Pulse: _____ Temp: _____

PMH: _____

PSH: _____

MEDS: _____

ALLERGIES: _____

	NORMAL	ABNORMAL
HEENT		
NECK		
NODES		
HEART		
LUNGS		
ABDOMEN		
EXTREMITIES		
SKIN		
BACK		
NEURO		
OTHER		

Remarks/Recommendations: _____

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: _____

Printed Name: _____

Address: _____

Phone: _____

Date: _____

Special Instructions:

Hepatitis B, MMR and Varicella titer results MUST be attached to this report.

Once completed, return this report to:

Diane Alcorn, RN, MUSOM Family Medicine, 1600 Medical Center Drive, Suite 1500, Huntington, WV 25701

Phone: 304-691-1110, Fax: 304-691-1153, Email: alcorn2@marshall.edu

*****The deadline to receive this information is July 1**