Marshall University Joan C. Edwards School of Medicine

Please return this form to:
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Phone: 304-691-8592
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STUDENT PHYSICAL EXAMINATION AND IMMUNIZATION FORM

Student Name: _____ Date of birth _____/_____/_____
LAST **FIRST**
Address: _____ Telephone No. _____

1. The following immunities are verified by **BLOOD TITER:** ***(IgG Lab Values must be attached)***

	Immunization Dates	**TITER Date & Result (Positive or Negative)**	**If negative titer, Reimmunization date**
Rubella (German Measles):	___/___/___; ___/___/___	_____	___/____/_____
Rubeola (Measles):	___/___/___; ___/___/___	_____	___/____/_____
Mumps:	___/___/___: ___/___/___	_____	___/____/_____
Varicella: (There are two varicella vaccinations in a series given 4-8 weeks apart, no titer needed if immunized for varicella)	___/___/___; ___/___/___	_____	___/____/_____

HEB B ***Hep. B Surface Antibody Results***
Hepatitis B Series Dates: ____/____/____; ____/____/_____; ____/____/_____ _____
(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 June 8)***
☐ **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