MARSHALL UNIVERSITY
Joan C. Edwards School of Medicine

1600 Medical Center Drive, Huntington, WV 25701

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	Serologic Immunity (IgG antibodies titer)		☐ Copy Attached
Mumps	Serologic Immunity (IgG antibodies titer)		☐ Copy Attached
Rubella	Serologic Immunity (IgG antibodies titer)		☐ Copy Attached

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	Hepatitis B Vaccine Dose #1		Result _____ml/ml ☐ Copy Attached
	Hepatitis B Vaccine Dose #2		
	Hepatitis B Vaccine Dose #3		
	QUANTITATIVE Hep B Surface Antibody		
Secondary Hepatitis B Series	Hepatitis B Vaccine Dose #4		
	Hepatitis B Vaccine Dose #5		
	Hepatitis B Vaccine Dose #6		
	QUANTITATIVE Hep B Surface Antibody		
Hepatitis B Vaccine Non-Responder (If Hep B Surface Antibody Negative after primary and secondary series)	Hepatitis B Surface Antigen (if 2nd titer negative)		☐ Copy Attached
	Hep B Core Antibody (if 2nd titer negative)		☐ Copy Attached
Chronic Active Hepatitis B	Hep B Surface Antigen		☐ Copy Attached
	Hep B Viral Load		☐ Copy Attached

Additional Comments:

Varicella (Chicken Pox) – 2 Doses of vaccine and positive serology, or positive serology only			
	Date		
	Varicella Vaccine #1		
	Varicella Vaccine #2		
	Serologic Immunity (IgG antibodies titer)		☐ Copy Attached

Tetanus-diptheria-pertussis – One dose of adult Tdap within the last 10 years			
	Vaccine	Date	
	Tdap Vaccine (Adacel, Boostrix, etc.)		☐ Copy Attached

Influenza vaccine – One dose annually, each fall.			
	Vaccine	Date	
	Flu Vaccine		☐ 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 1, 2020.**

Section A Negative Skin or Blood Test History		Date Placed	Date Read	Reading	Interpretation
	TST #1			mm	☐ Positive ☐ Negative
	TST #2			mm	☐ Positive ☐ Negative
	TST #3			mm	☐ Positive ☐ Negative
				Result	
	IGRA Blood Test			☐ Negative ☐ Indeterminate	☐ Copy Attached

Section B History of Latent Tuberculosis, Positive Skin Test, or Positive Blood Test		Date Placed	Date Read	Reading	Interpretation
	Positive TST			_____mm	
				Result	
	Date of Positive IGRA			_____IU	☐ Copy Attached
	Date of Chest X-Ray				☐ Copy Attached
	Prophylactic Medications for latent T B taken?				☐ Yes ☐ No
	Total Duration of prophylaxis				_____Months

Section C History of Active Tuberculosis			
	Date of Diagnosis		
	Date Treatment was Completed		☐ Copy Attached
	Date of Last Annual CXR		☐ Copy Attached

Additional Comments:

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 June 1.***