PROFESSIONAL PROGRAMS

_____ EXERCISE PHYSIOLOGY _____ OCCUPATIONAL THERAPY _____ PHYSICAL THERAPY

MED.LAB.SCIENCE:_____ Clinical Laboratory Sciences _____Pathologist's Assistant _____Histotechnology

STUDENT'S HEALTH EVALUATION FORM

PART 1 - To be completed by student

Name_____ Age_____ Date of Birth_____/_____/_____

Permanent Address_____

In case of emergency, notify: Name_____ Phone__(_____)_____

Relationship_____ Address_____

Student's 700#_____

STUDENT'S MEDICAL HISTORY

Allergies	
Operations (date, type)	
Hospitalizations (date, type)	
Medical, emotional problems requiring treatment	
Medications	

STUDENT'S FAMILY HISTORY

FAMILY MEMBER	AGE(S)	STATE OF HEALTH
Mother		
Father		
Brother(s)		
Sister(s)		
Spouse		
Children		

What is your current health status?_____

Comments or additional history:_____

To my knowledge, the Medical History and Immunization information I have provided on this form is accurate and complete. I give permission to the Associate Dean and staff of Professional Programs of the WVU School of Medicine to release the necessary parts of my health forms, including records and titer results when required for on-campus clinical rotations and rotations at other institutions to which I am assigned.

Student's Signature:_____ Date:_____

PART 2 - PHYSICAL EXAMINATION ***(To be completed by physician)***

Name_____ Age_____ Date of Birth_____/_____/_____

Height _____ Weight _____ Pulse _____ Respiration _____ Blood Pressure _____

Vision: OD _____/20; OS _____/20 Hearing: R _____/15; L _____/15

	NORMAL	ABNORMAL	COMMENTS
HEENT			
Neck			
Chest			
Lungs			
Heart			
Abdomen			
Genitalia			
Extremities			
Orthopedic			
Neurologic			

Summary of medical problems/concerns:

Physician Name (Please print)_____

Physician Signature_____ Date of Exam_____

IMMUNIZATION VERIFICATION FORM

Name_____ Age_____ Date of Birth_____/_____/_____

Gender: M_____ F_____ Allergies:_____

Record the dates of immunizations and titers below, indicating titer results and values as indicated. The student will be required to furnish separate documentation of any required immunizations or titers not recorded on this form.

Immunization or Training	Immunization/Training Date						Titer Date	Result (+) (-) Record Actual Titer Values
Tetanus[1]								
Polio								
Measles[5] **(Rubeola)**								**MMR * VARICELLA * HEP B** **TITER RESULTS MUST BE ATTACHED.** **Results must be read and approved by physician.** ***Physician must sign off on the TITER result page(s).***
Mumps[5]								
Rubella[5]								
Varicella[2,5]	Had As Child ____	Date of Immunization if did not have disease.						
Hepatitis #1								
Hepatitis #2								
Hepatitis #3								
PPD[4] *2 STEP is REQUIRED for the first time*	1st Yr.	2nd Yr	3rd Yr.	4th Yr.	5th Yr.	6th Yr.		
Meningitis Shot[6]								
BCG[3]								
Pneumovax[3]								
Influenza[3]								

[1] Tetanus must be given within the last 10 years.
[2] May record a disease if not immunized.
[3] BCG, Pneumovax, Influenza, if indicated. [These immunizations are NOT required, but we need to know if you have received them.]
[4] PPD must be administered within six (6) months of starting the Exercise Physiology, Occupational Therapy or Physical Therapy curriculum. (2 Step is REQUIRED)
[5] Titers are REQUIRED for Measles (Rubeola), Mumps, Rubella, Hepatitis B, and Varicella. Actual lab results MUST be submitted.
[6] Meningitis shot is now "required".

FOR OFFICE USE ONLY						
CPR CARD (needs renewed by)						
INSURANCE CARD						
HIPAA TRAINING						
OSHA TRAINING						
FINGER PRINT & BACKGROUND CHECK						

To my knowledge, the Immunization information I have provided on this form is accurate and complete. I give permission to the Associate Dean and staff of the Professional Programs of the WVU School of Medicine to release the necessary parts of my health forms, including records and titer results when required for on-campus clinical rotations and rotations at other institutions to which I am assigned.

Student's Signature:_____ **Date:**_____