# Student Health Clearance Certificate

Name _____ Date of Birth _____
(Last, First, Middle)

Address _____ Phone _____

City _____ State _____ Zip Code _____

Semester: O Winter 20___ O Summer 20___ O Fall 20___

**All Test Results must be attached with this form.**

## I. Tuberculin Skin Test:

(Mandatory within one year except those with positive skin test history.)

Type of Test: _____ Date Tested: _____ Date Read: _____

O Positive O Negative

**For those with a history of positive tuberculin test, the following is mandatory:**

Date of last chest X-ray: _____

Radiologist X-ray report: O Positive O Negative

## II. HIV Test:

(Mandatory within six months)

Date Tested: _____

O Positive O Negative

(Positive results will not necessarily bar a person from staying in St. Maarten, but will require liaison with the local health authorities.)

## III. Mandatory Proof of Immunity

Hepatitis B: 1st Date: _____/_____/_____ 2nd Date: _____/_____/_____ 3rd Date: _____/_____/_____

Hepatitis C: Blood Screen Date: _____ Titer Count: _____

Measles: Vaccine Date: _____ Titer Count: _____

Mumps: Vaccine Date: _____ Titer Count: _____

Rubella: Vaccine Date: _____ Titer Count: _____

Varicella: Vaccine Date: _____ Titer Count: _____

Poliomyelitis: Vaccine Date: _____ Titer Count: _____

Diphtheria: Vaccine Date: _____ Titer Count: _____

Pertussis: Vaccine Date: _____ Titer Count: _____

Tetanus: Vaccine Date: _____ Titer Count: _____

Influenza: Vaccine Date: _____ Titer Count: _____

## IV. Signatures

**To be filled out by a health provider:**

1. Does this student have any acute/chronic health problems? If yes explain.

2. Date of last physical exam: _____/_____/_____

Results of the exam: _____

Physician's printed Name: _____ Licence # _____

Office Address: _____

City _____ State _____ Zip Code _____

Country: _____

Telephone: _____ Email: _____

**I verify that the information is true.**

Signature of Physician: _____ Date _____

**Statement of Self Declaration of Fitness**

I, _____, state that I am physically fit and free of habituation or addiction to depressants, stimulants, narcotics, alcohol, and/or other drugs or substances which may alter my behavior of effect my judgment. Any false information, omission, or misrepresentation will constitute grounds for dismissal from the University.

Signature of Student: _____ Date _____

Verified by AUC Official: _____ Date _____

Note: *All AUC students are required to have adequate global health insurance coverage. All Medical Sciences students must enroll in the AUC sponsored student health insurance policy underwritten by National General Insurance Corporation, NV (NAGICO). This is a requirement to receive a student residency permit from the government of St. Maarten.*

**Please return Student Health Clearance Certificate to:**
**American University of the Caribbean School of Medicine**
**901 Ponce de Leon Blvd., Suite 700, Coral Gables, Florida 33134**