



STUDENT HEALTH CLEARANCE CERTIFICATE

Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

**A HEALTH CARE PROVIDER MUST COMPLETE THE FOLLOWING
ALL TEST RESULTS MUST BE ATTACHED WITH THIS FORM**

I. TUBERCULIN SKIN TEST

(Must be less than one year old. All tuberculin skin tests must be valid through the entire clinical clerkship)

Date Tested: _____ Date Read: _____

Result: Positive Negative Induration: _____ mm

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

Date of last chest X-ray: _____

Chest X-ray report: Positive Negative

II. IMMUNIZATION RECORD

(Students must prove immunity to ALL of the following prior to commencement of clinical clerkships)

HBsAb titer result: Positive/Immune/Past Exposure Negative/Non-Immune

Hepatitis B Vaccine: 1st: ____/____/____ 2nd: ____/____/____ 3rd: ____/____/____
(MM/DD/YYYY) (MM/DD/YYYY) (MM/DD/YYYY)

Measles: Vaccine Date: _____ Titer Level: _____ Immune or Non-Immune

Mumps: Vaccine Date: _____ Titer Level: _____ Immune or Non-Immune

Rubella: Vaccine Date: _____ Titer Level: _____ Immune or Non-Immune

Varicella: Vaccine Date: _____ Titer Level: _____ Immune or Non-Immune

Influenza: Vaccine Date: _____



HANDA

MEDICAL GROUP

Date of last physical exam: _____ / _____ / _____
(MM/DD/YYYY)

Results of the exam:

Name of Physician: _____ Specialty: _____

Office Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Telephone: _____ Email: _____ Fax: _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE.

SIGNATURE OF PHYSICIAN: _____ **DATE:** _____

**Please attach test results with this form*

LICENSED SPECIALIST STAMP OR BUSINESS CARD



TO BE COMPLETED BY THE STUDENT

GENERAL HEALTH

List any recent or continuing health concerns: _____

List any physical or learning disabilities: _____

Are you currently seeing a physician for an ongoing health issue? Yes No

If yes, Physician's Name: _____ Telephone: _____

Address: _____

For what condition(s):

Surgeries

List type and year:

Drug or Food Allergies

List any drug or food allergies and briefly describe reaction:

Medication

List any prescribed medication and briefly describe for what reason:



MEDICAL HISTORY

Please check if you have ever had any of the following:

- | | | | |
|--------------------------------|--------------------------|--------------------------------|--------------------------|
| Headaches requiring treatment: | <input type="checkbox"/> | Ulcer/colitis: | <input type="checkbox"/> |
| Epilepsy/seizures: | <input type="checkbox"/> | Hepatitis/gallbladder disease: | <input type="checkbox"/> |
| Asthma/lung disease: | <input type="checkbox"/> | Bladder/kidney problems: | <input type="checkbox"/> |
| Heart disease: | <input type="checkbox"/> | Diabetes: | <input type="checkbox"/> |
| Anemia or bleeding disorder: | <input type="checkbox"/> | Cancer/tumors: | <input type="checkbox"/> |
| Back/joint problems: | <input type="checkbox"/> | Thyroid problems: | <input type="checkbox"/> |
| High blood pressure: | <input type="checkbox"/> | Recurrent infectious diseases: | <input type="checkbox"/> |

Other: _____

CERTIFICATION

I certify that all responses made on this form are complete, true and accurate. I understand that if there are any changes in my health status, I will contact Handa Medical Group immediately. I understand that if I misrepresented or failed to provide the information requested on this form, then I may be terminated from participation in or dismissed from my clinical clerkships.

STUDENT SIGNATURE: _____ DATE: _____