HANDA
MEDICAL GROUP

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 then 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: _____

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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

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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:

_____

_____

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MEDICAL HISTORY

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

Headaches requiring treatment:	☐	Ulcer/colitis:	☐
Epilepsy/seizures:	☐	Hepatitis/gallbladder disease:	☐
Asthma/lung disease:	☐	Bladder/kidney problems:	☐
Heart disease:	☐	Diabetes:	☐
Anemia or bleeding disorder:	☐	Cancer/tumors:	☐
Back/joint problems:	☐	Thyroid problems:	☐
High blood pressure:	☐	Recurrent infectious diseases:	☐

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: _____