ST CHRISTOPHER IBA MAR DIOP COLLEGE OF MEDICINE

PART 1 HEALTH HISTORY:

Answer yes or no. If the question below is yes, provide names and addresses of all physicians or healthcare providers who participated in the diagnosis, referral or treatment. Give details, reasons and dates as appropriate space below or additional pages if necessary.

A. Has your physical activity been restricted or your education interrupted for medical, surgical or psychiatric reasons during the past five years? Yes No

_____

_____

B. Have you ever received treatment or counselling for a psychiatric condition, personality or character disorder or emotional problem? Yes No

_____

_____

C. Have you ever had any illness or injury which required treatments by physician, surgeons, psychiatrist or other healthcare worker? Yes No

_____

_____

D. Have you ever been hospitalised for more than three days? Yes No

_____

_____

E. Have you ever had a surgical operation? Yes No

_____

_____

F. Please list any medication you are taking regularly:

_____

_____

_____

G. Please list any allergies:

_____

_____

_____

H. Do you have any condition which requires special consideration or treatment? Yes No

_____

_____

I. Have you ever been denied medical or life insurance? Yes No
If yes please give details.

_____

_____

_____

Additional student/examining physician information

_____

_____

_____

_____

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PART II PHYSICAL EXAMINATION:

NAME: **SOCIAL SECURITY NUMBER:**

To the Examination physician:
Please review the student's history and complete applicable parts of the examination form.
Please comment on all positive answers.

Height Weight Blood Pressure Pulse Vision
Right 20/
Left 20/
Corr 20/ to 20/

Describe any abnormalities of the following systems in the space below:

Eyes:	
ENT	
Neck	
Lungs	
Heart	
Breast	
Abdomen	
Rectum	
Nervous System	
Genitalia	
Extremities	

I have determined that is free from any health impairment which is of potential risk to patients or which might interfere with the performance of his/her duties. This includes the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or "substances" which may alter the individual's behaviour.

Date: Signature:

County of state license: Physician's name:

Address: Zip code:

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PART III IMMUNIZATION RECORD

Name:

Date of Birth: Social Security Number:

Permanent address:

To be completed and signed by a healthcare provider. All dates should include month and year. Include the manufacturer's name and lot number whenever possible.

A. TUBERCULOSIS SCREENING

Date	Manufacturer and lot number of the Protein. Derivative used in a standard	Results in mm	Signature of health care provider.

If the PPD is positive (equal to or > 10mm) a chest x-ray must be done immediately and yearly. Once a PPD is positive, a copy of the report must be sent to Medical School Services, Ltd immediately and yearly thereafter. In addition, a record of the chest x-ray must be noted at the end of this form under section E

B. **REQUIRED IMMUNIZATION**
Please see instructions on the front page. Check boxes where appropriate.

	Date	Manufacturer & Lot Number	Signature of healthcare Provider.
Tetanus-diphtheria (TD) **a.** TD booster within the last 10 years			
Measles, Mumps, Rubella (MMR) a. 2 immunizations at least 30 days apart.			
b. Positive serum antibody titer to MMR			

	Date	Manufacturer & Lot Number	Signature of healthcare Provider.
Hepatitis B a. immunization at 0, 1 month and 6 months			
b. Positive serum antibody titer results international units.			
c. Booster (if necessary)			
Polio a. Complete primary series of polio immunization			
b. Booster Live vaccine (OPV) Inactivated (IPV)			

C. RECOMMENDED IMMUNIZATIONS:

Hepatitis A a. 2 vaccinations at least 6 months			
b. positive serum antibody titer.			

D. ADDITIONAL IMMUNIZATIONS:

E. CHEST X-RAY

For those students with a positive PPD, complete the following in addition to sending an official chest x-ray report to Medical School Services, Ltd.

Date _____ Result _____ Radiologist _____