UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
STUDENT PRE-ENROLLMENT MEDICAL EXAMINATION FORM

TO STUDENT: Please complete the personal information below. Your physician must complete the remaining portion of this form. This form must be received by Employee Health/Student Preventive Health Service at the following address **BEFORE** registration.

Employee Health/Student Preventive Health Services (EH/SPHS)
521 Jack Stephens Drive
Little Rock, AR 72205
(501) 686-6565 Fax (501) 296-1230
Slot 530-8

Return this form by:________________

PERSONAL INFORMATION: **(To be completed by student)**

Name ____Age______Social Security No. ________________________
Last First Middle

Current Address:____City____________________State_____Zip____________

Male_____Female_____DOB___________Race_____Home Phone No.__________________Message No.______________________

School: Medicine____Pharmacy____Nursing____CHRP______(program)_____________Grad______(program)______________

IMMUNIZATION HISTORY: (To be completed only if given by nurse or physician otherwise attach copies)
Immunization dates must include at least month and year

Tetanus-Diphtheria (Td): Booster **required within the past 10 years**

Date: __________

Measles: For Rubeola (measles), UAMS students must show one of the following as proof of immunity:
1) Documentation of **2 doses of measles** (or MMR) vaccine after the first birthday (no less than 1 month apart). **Measles injections administered before 1968 do not count as documented by the State Health Department.**
2) A rubeola titer demonstrating immunity. 3) A letter from a physician stating that the student has had the rubeola disease.

Dates: __________ __________ Date of Titer:_________ (Attach results)

Mumps: All students born in or after 1957 must have documentation of a single dose of mumps or MMR vaccine (after 1968), physician diagnosed mumps, or laboratory evidence of mumps immunity.

Dates: __________ __________ Date of Titer: _________ (Attach results)

Rubella: All students (regardless of age) must have documentation of a single dose of MMR vaccine after their first birthday (after 1/1/1969) or laboratory evidence of immunity.

Dates: __________ __________ Date of Titer: ___________ (Attach results)

Hepatitis B dates: ______________ ______________ _______________

Are you a foreign-born student? No____ Yes____ If yes, what country_____________________________

TB Testing: Have you ever had a positive tuberculosis skin test? ______**If yes, attach documentation of date and reaction (in millimeters) to EH/SPHS.**

MEDICAL HISTORY: (To be completed by physician)

1. List any known allergies:

2. List any (previous and current) serious medical problems and chronic illnesses:

3. List previous hospitalizations including location and purpose of admission:

4. History of Chickenpox? Yes______No______Unsure______

5. List all current medications (to include over the counter and alternative medications).

Examination: (To be completed by physician) **[Please describe abnormality]**

Height___________Weight___________Pulse___________B/P___________

Eyes: (including vision)

Ears: (including hearing)

Nose:

Throat:

Chest and lungs:

Heart:

Abdomen:

Bones, Joints, Extremities:

Nervous System:

Remarks and Recommendations:

I certify that I have evaluated this patient in the past 3 months and the above information is true.

___________ ____ ______________________________

Date **Signature of Examining Physician** **Type or Print Name of Physician**

____________________________________ __________________________ ________ ____________

Address **City** **State** **Zip Code**

I certify that all information contained on this form is correct.

_______________________________________ _________

Student Signature **Date**