Institute of
Health Sciences

Quality Education. Lifetime Opportunity.

Student Health Certification

I, _____, authorize medical information provided by my Primary Care Provider to be released to the Institute of Health Sciences, 1300 York Road, Timonium, MD 21093

Date: _____ Student Signature: _____

Name (Last, First, M.I.): Please print clearly		**Today's Date:**	
Social Security #:		**Date of Birth:**	
Program:			

All the information above must be completed in order to process this form.

If you have any questions, contact the person at the Institute of Health Sciences who is processing your student application.

All persons working in a healthcare setting with patients or families, or working in a building where patients are seen, must provide proof of immunity as indicated below. This form must be signed by your healthcare provider, or alternatively you can attach your immunization and TB screening records.

MEASLES (Rubeola)

Born 1957 or after: 2 measles vaccines (measles or MMR) given after your first birthday; or physician documented disease; or positive blood titer

Immunizations & dates: Please check all that apply & date	☐ Measles Vaccine Date# 1:	☐ Measles Vaccine Date# 2
	☐ MMR Vaccine *Measles, Mumps, Rubella* Date # 1:	☐ MMR Vaccine *Measles, Mumps, Rubella* Date # 2:
	☐ Disease Date:	☐ Positive blood titer Date:

Born before 1957 : 1 measles vaccine (measles or MMR) given after your 1st birthday; or physician documented disease; or positive blood titer

Immunizations & dates: Please check all that apply & date	☐ Measles Vaccine Date:	☐ MMR Vaccine *Measles, Mumps, Rubella* Date:
	☐ Disease Date documented:	☐ Positive blood titer Date:

MUMPS

Born 1957 or after: 2 mumps vaccines (mumps or MMR) given after your first birthday, or physician documented disease, or positive blood titer

Immunizations & dates: Please check all that apply & date	☐ Mumps Vaccine Date# 1:	☐ Mumps Vaccine Date# 2:
	☐ MMR Vaccine *Measles, Mumps, Rubella* Date # 1:	☐ MMR Vaccine *Measles, Mumps, Rubella* Date # 2:
	☐ Disease Date documented:	☐ Positive blood titer Date:

Born before 1957: 1 mumps vaccine (mumps or MMR) given after your first birthday, or physician documented disease, or positive blood titer.

Immunizations & dates: Please check all that apply & date	☐ Mumps Vaccine Date:	☐ MMR Vaccine *Measles, Mumps, Rubella* Date:
	☐ Disease Date documented:	☐ Positive blood titer Date:

RUBELLA (German measles)

1 rubella vaccine (rubella or MMR) given after your first birthday or positive blood titer.
Physician documented disease is not acceptable for rubella. Requirement same for all age groups.

Immunizations & dates: Please check all that apply & date	☐ Rubella Vaccine Date:	☐ MMR Vaccine *Measles, Mumps, Rubella* Date:
	☐ Blood titer Date: Results:	

Varicella (chicken pox)

Reliable history of disease, or 2 vaccines, or positive titer

Immunizations & dates: Please check all that apply & date	History of Varicella disease: ☐ Yes ☐ No History of zoster (shingles) ☐ If yes, Date:	
	☐ Blood titer Date: Results:	
	☐ Varicella Vaccine Date # 1:	☐ Varicella Vaccine Date # 2:

Hepatitis B

(required for anyone at risk of coming in contact with human blood or body fluids)

Immunizations & dates: Please check all that apply & date	☐ Vaccine X 3 Dates (if known) Date# 1: Date# 2: Date# 3:	Or Year completed Vaccine course:
	☐ Positive Hepatitis B antibody titer Date:	

Tdap (Tetanus, diphtheria, and acellular pertussis)

Highly recommended for anyone with direct patient contact, especially with infants)

Immunizations & dates: Please check all that apply & date	☐ Tdap Vaccine Date:

Influenza vaccine

(required for anyone working with patients during flu season - offered free of charge by CHOP)

	☐ Influenza Vaccine Date:	Type of Vaccine ☐ Flu Shot ☐ Flu Mist

TB Screening

(must be current within 3 months of start date - offered free of charge by CHOP)
Note: students who are required to get TB skin tests for other rotations must have a PPD current within 1 year.

Most recent TB skin test: Date: _____	Results: _____ mm
If PPD positive, complete TB questionnaire. You will need to indicate date of conversion, post conversion chest X-ray and treatment received. Attach copy of chest X-ray report.	
Student is FREE from TB or other communicable disease that might present a health hazard to patients or other personnel.	Yes _____ No _____
The student is in satisfactory physical condition & able to provide basic medical care including lifting patients. Comment:	Yes _____ No _____
Healthcare Provider Name: (Please print)	
Healthcare Provider Signature:	Date: