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 the Student Services Office 2 weeks prior to the start of your first semester.

UAMS College of Nursing
Student Services Office
4301 West Markham, #529
Little Rock, AR 72211

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 the month and the year.

Tetanus-pertussis (Tdap): Booster (**Required with the past 10 years-or Td if less than 2 years since booster)**

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** 2) a rubeola titer demonstrating immunity, 3) a letter from a physician stating that the student has had the rubeola disease, 4) Date of birth prior to 1952.

Dates: _____ _____ or Date of Titer: _____ (Attach Results)

Mumps: All students born in, or after, 1957 must have documentation of 1) a single dose of mumps or MMR vaccine (after 1968,) 2) a letter from a physician stating that the student has had the mumps, or 3) a mumps titer demonstrating immunity.

Dates: _____ _____ or Date of Titer: _____ (Attach Results)

Rubella: All students (regardless of age) must have documentation of a sing dose of MMR vaccine after their first birthday (after 1/1/1969,) or 2) a rubella titer demonstrating immunity.

Dates: _____ _____ or Date of Titer: _____ (Attach Results)

Hepatitis B 3-shot series: (or positive titer for Hepatitis B antibodies)

Dates: _____ _____ _____ or Date of Titer: _____ (Attach Results)

Varicella: UAMS students must show documentation of 2 doses of varicella vaccine, or a varicella titer showing immunity, or a health care provider documentation of varicella disease or herpes zoster.

Dates: _____ _____ _____ or Date of Titer: _____(Attach Results)

**If any of the above requirements cannot be met due to contraindications to vaccines, immunosuppression, etc., students should provide a waiver from their health care provider.*

Are you a foreign-born student? No_____ Yes_____ If yes, what country _____
Have you received the **B.C.G. vaccine**? No_____ Yes_____

TB Testing: Have you ever had a positive tuberculosis skin test? No_____ Yes_____
If yes, attach documentation of date, reaction in millimeters, chest x-ray, and course of treatment.
PPD or Skin Test:

Date placed:_____ Date Read: _____ Results: _____ Signature: _____

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

MEDICAL HISTORY: (To be completed by the 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_____

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

EXAMINATION: (To be completed by the 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 three 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**