

SABA UNIVERSITY SCHOOL OF MEDICINE

Clinical Immunization Form

Please return this form to:
 Clinical Department
 27 Jackson Rd., Suite 301
 Devens, MA 01434



Phone: 978-862-9600
 Fax: 978-862-9699

STUDENT PHYSICAL EXAMINATION AND IMMUNIZATION FORM

Student Name: _____ Date of Birth ___/___/___
Last *First*

Address: _____ Telephone No.: _____

	TITER Date & Result (Positive or Negative)	If negative titer, Re-immunization date (Booster)	Follow-up Re-immunization (Titer) results & date
Rubella (German Measles):	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	___/___/___	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Rubeola (Measles):	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	___/___/___	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Mumps:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	___/___/___	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Varicella:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	___/___/___	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Hep B	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	___/___/___	<input type="checkbox"/> Positive <input type="checkbox"/> Negative

Hep B Titer MUST be drawn at least 4 weeks after completion of series.

2. Tuberculosis:

a. PPD (Mantoux) Date: ___/___/___ Negative Positive _____ mm reading
 Updates: Date: ___/___/___ Negative Positive _____ mm reading
(If positive, please indicate the date and results of the most recent chest x-ray and whether or not any therapy has been initiated) ___/___/___ _____

Or:

b. Blood Test (i.e. Gold Test or T-SPOT): ___/___/___ Positive Negative Indeterminate
 Updates: ___/___/___ Positive Negative Indeterminate

3. Tetanus-Diphtheria (Must be within last 10 years) Date: ___/___/___ (Update) ___/___/___

4. Is the student presently taking any form of medication prescribed by a physician? No Yes
 If yes, please list the medications: _____

Physical Examination:
 I have performed and recorded a physical examination and the medical history of the above named student which failed to reveal any health impairment which may be of potential risk to patients or which might interfere with the performance of his/her duties nor any habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which alter mood or behavior.

 Signature of Physician Print Name Address Date

Titer Lab Report must be attached

 Saba Authorized Signature

 Date

This Form Has Been Updated on Date: _____ Item updated: 2. TB 3. Tetanus