



POZNAŃ UNIVERSITY OF MEDICAL SCIENCES
STUDENT HEALTH DEPARTMENT

70 Bukowska Street, D-2 Room# 230, 60-812 Poznań, Poland
tel. + 48 61 854 71 42-46

PRE- CLINICAL ROTATION HEALTH ASSESSMENT FORM

Personal Data

Name: _____ Date: _____
Last First Middle (Mo/Day/Yr)

Student ID#: _____

Date of Birth: _____ Sex: Female Male
(Mo/Day/Yr)

Physical Exam

Student _____ was examined on _____ and found to be physically and mentally fit to participate in direct patient contact within the scope of his/her activities as a medical student on duty at health care facilities.

This student has the following limitations (if any): _____

Additional Comments: _____

Date: _____
(Mo/Day/Yr)

Student Health Officer/ Attending Physician



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IMMUNIZATION RECORD

STUDENT'S NAME: _____ **D.O.B.:** _____ **ID#:** _____

Measles: Proof of immunity to measles means two doses of live vaccine administered on or after 12 months of age, separated by at least one month and/or serologic evidence of immunity.

Primary Vaccinations #1 Date: ___/___/___
#2 Date: ___/___/___
OR Positive Titer Date: ___/___/___ Result: _____
OR Additional Vaccination Date: ___/___/___

Mumps: Proof of immunity means one dose of mumps vaccine administered on or after the first birthday and/or serologic evidence of immunity.

Primary Vaccination #1 Date: ___/___/___
OR Positive Titer Date: ___/___/___ Result: _____
OR Additional Vaccination Date: ___/___/___

Rubella: Proof of immunity means one dose of rubella vaccine administered on or after the first birthday and/or serologic evidence of immunity.

Primary Vaccination #1 Date: ___/___/___
OR Positive Titer Date: ___/___/___ Result: _____
OR Additional Vaccination Date: ___/___/___

Varicella: Documented history of Varicella: Yes No Date: ___/___/___

If No: Varicella Titer: Date: ___/___/___ Result: _____

If negative titer, two vaccinations required: #1 Date: ___/___/___ #2 Date: ___/___/___

Tetanus/Diphtheria: Primary series plus Td booster within last 10 years Date: ___/___/___

Hepatitis B:

Vaccine series completed: 1st Date: ___/___/___ 2nd Date: ___/___/___ 3rd Date: ___/___/___

Hepatitis B Surface Ab Titer: Date: ___/___/___ Result: _____ (copy of lab report required)

PPD Tuberculin Test:

Date: (within six months) ___/___/___ Negative Positive Result: _____ mm

If above test positive, a chest x-ray required Date: ___/___/___ Result: _____

Copy of the chest x-ray report must be submitted

OTHER: (not required by our institution)

Hepatitis A: #1 Date: ___/___/___ #2 Date: ___/___/___

Polio: series of 4 completed, last dose: Date: ___/___/___

Meningococcal: Date: ___/___/___

I have examined the above named student who is free from any health problems within last 12 months that would pose a potential risk to patients or hospital personnel. The health status of the above named individual should not interfere with the performance of his/her duties. In addition I attest to all the immunization information above.

Physician's Name: _____ **Date:** _____
(Mo/Day/Yr)

Physician's Signature: _____

Address: _____

Stamp