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**

Date:_____
*(Mo/Day/Yr)*

Name: _____ Student ID#: _____
*Last First Middle*

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:____/____/____

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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