



International American University — College of Medicine

Website: www.iau.edu.lc

Toll Free: 888.440.4474

Email: admissions@iau.edu.lc

Admissions Office: 5999 Summerside Drive, Suite 220, Dallas , TX 75252

HEALTH AND IMMUNIZATION

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I, DR. _____, AM EXAMINING THE CANDIDATE LISTED BELOW FOR ADMISSION INTO A MEDICAL SCHOOL. I DO HEREBY CERTIFY THAT THE ABOVE STUDENT IS IN GOOD HEALTH AND IS NOT SUFFERING FROM ANY COMMUNICABLE DISEASES. I ALSO CERTIFY THAT I DO NOT SEE ANY PHYSICAL OR MENTAL IMPEDIMENT IN THIS CANDIDATE, WHICH WOULD PRECLUDE SUCCESSFUL COMPLETION OF HIS OR HER MEDICAL EDUCATION.

REQUIRED FOR BASIC SCIENCE STUDENTS

General Health Good Fair Poor

Date of Examination _____ Physician's Name: _____

Address: _____

Tel No.: _____ Fax No.: _____

Physician's Signature: _____

STUDENT INFORMATION

Name: _____
Last First Middle Initial

Address: _____
Street City State Zip Code

DOB: _____ SS# _____
MM/DD/YYYY

Primary Phone#: _____ Please indicate: Home Cellular Work

Secondary Phone #: _____ Please indicate: Home Cellular Work



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IMMUNIZATION HISTORY (DT/Td within 10 years date)

MEASLES (2 doses at least one month apart, after 12 months age)

Date#1: _____

Date#2: _____

MUMPS (1 dose)

Date: _____
or proof of immunity (mumps titre) Date & Results _____

RUBELLA (German Measles, 1 dose)

Date _____
or proof of immunity (rubella titre) Date & Results _____

CHICKENPOX

History of having had chickenpox (Please check one): Yes No

***PPD** (Mantoux)

Date & Results: _____
(must be within one year and updated annually) Chest x-ray is required if tested positive.

Positive PPD Test Dates: _____

BCG Vaccine & Chest X-ray (Non-US) _____

HIV

Test Date & Results: _____
(must be current within 60 days of matriculation)

REQUIRED PRIOR TO CLINICAL PROGRAM

For those individuals having direct patient contact or any possibility of contact with blood of body fluids, Hepatitis series or declination is required.

Hepatitis B Vaccine

Date #1: _____ Date #2: _____ Date #3: _____

HBSAB following series--Date & Results: _____

Declination signed and on file Date: _____

Physician Initials

Date