Name:_____ Date of Birth:_____
Address:_____ Telephone: _____
City:_____ State/Province:_____ Zip/Postal:_____

A HEALTH CARE PROVIDER MUST COMPLETE THE FOLLOWING
ALL TEST RESULTS MUST BE ATTACHED WITH THIS FORM

I. TUBERCULIN SKIN TEST

(Must be less than one year old. All tuberculin skin tests must be valid through the entire clinical clerkship)

Date Tested: _____ Date Read: _____

Result: oPositive oNegative Induration: _____mm

For those with a history of a positive tuberculin test, the following is mandatory:

Date of last chest X-ray: _____

Chest X-ray report: oPositive oNegative

II. IMMUNIZATION RECORD

(Students must prove immunity to ALL of the following prior to commencement of clinical clerkships)

HBsAb titer result: oPositive/Immune/Past Exposure oNegative/Non-Immune

Hepatitis B Vaccine: 1st: _____/____/_____ 2nd: ____/____/_____ 3rd: _____/____/_____
(MM/DD/YYYY) (MM/DD/YYYY) (MM/DD/YYYY)
Measles: Vaccine Date: _____ Titer Level: _____ Immune or Non-Immune
Mumps: Vaccine Date: _____ Titer Level: _____ Immune or Non-Immune
Rubella: Vaccine Date: _____ Titer Level: _____ Immune or Non-Immune
Varicella: Vaccine Date: _____ Titer Level: _____ Immune or Non-Immune
Influenza: Vaccine Date: _____

833 West Chicago Ave, Suite 216, Chicago, IL, 60642 Tel: 708-598-5600
Fax: 708-876-8800. Email: aiclinicalgroup@gmail.com

Date of last physical exam: _____/_____/_____

(MM/DD/YYYY)

Results of the

exam:_____

_____

Name of Physician:_____Specialty:_____

Office Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Telephone: _____ Email: _____ Fax: _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE.

SIGNATURE OF PHYSICIAN: _____ DATE: _____

*Please attach test results with this form

LICENSED SPECIALIST

STAMP OR SEAL

GENERAL HEALTH

List any recent or continuing health concerns: _____

List any physical or learning disabilities:_____

Are you currently seeing a physician for an ongoing health issue? oYes oNo

If yes, Physician's Name: _____ Telephone:_____

Address:_____

condition(s):_____

_____

Surgeries

List type and year: _____

_____

Drug or Food Allergies

List any drug or food allergies and briefly describe reaction:

_____

_____

Medication

List any prescribed medication and briefly describe for what reason:

_____

_____

MEDICAL HISTORY

Please check if you have ever had any of the following:

Headaches requiring treatment: o Ulcer/colitis: o Epilepsy/seizures: o Hepatitis/gallbladder disease: o

Asthma/lung disease: o Bladder/kidney problems: o Heart disease: o Diabetes: o

Anemia or bleeding disorder: o Cancer/tumors: o Back/joint problems: o Thyroid problems: o

High blood pressure: o Recurrent infectious diseases: o

Other: _____

CERTIFICATION

I certify that all responses made on this form are complete, true and accurate. I understand that if there are any changes in my health status, I will contact AICG immediately. I understand that if I misrepresented or failed to provide the information requested on this form, then I may be terminated from participation in or dismissed from my clinical clerkships.

STUDENT SIGNATURE: _____ DATE: _____