# UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
# STUDENT PRE-ENROLLMENT MEDICAL EXAMINATION FORM

**TO STUDENT:** Please complete the personal information below. This form must be received by Employee Health/Student Preventive Health Services 30 days **PRIOR** to registration by uploading the information into the Student's GUS account. **Do not e-mail, fax or mail documentation.**

**Employee Health/Student Preventive Health Services (EH/SPHS)**
**521 Jack Stephens Drive, Mail Slot 530-8**
**Little Rock, AR 72205**
**501-686-6565 (office) StudentandEmployeeHealth@uams.edu**

**PERSONAL INFORMATION:**

Name_____Age_____Last four of Social Security No._____
Last First Middle

Current Address_____City_____State_____Zip_____

Male ____Female ____DOB_____Race _____Home Phone No ._____Message No._____

School: Medicine _____ CHP_____ (program) _____ COPH_____

**IMMUNIZATION HISTORY:** (**Immunization dates must include the month, day, and the year. Documentation must be provided.)**

_____ **Tetanus-pertussis (Tdap):** Booster (**Required with the past 10 years-or Td if less than 2 years since booster)**

_____ **Measles:** For Rubeola (measles,) must show one of the following as proof of immunity; 1) Documentation of **2 doses of measles** (or MMR) vaccine after the first birthday (no less than 1 month apart) Students born in 1956 or before may provide documentation of a single dose Or 2) a rubeola titer demonstrating immunity,

_____ **Mumps:** Documentation of 1) a single dose of mumps or MMR vaccine, or 2) a mumps titer demonstrating immunity.

_____ **Rubella:** All students must have documentation of a single dose of MMR vaccine after their first birthday or 2) a rubella titer demonstrating immunity.

_____ **Hepatitis B 3-shot series:** (or positive titer for Hepatitis B antibodies)

_____ **Varicella:** All students must show documentation of 2 doses of varicella vaccine or a varicella titer showing immunity

_____ **Influenza:** Seasonal influenza vaccine (or novel influenza vaccine if so recommended by the Center for Disease control) (INACTIVATED) will be **required annually for all students**.

**If any of the above requirements cannot be met due to contraindications to vaccines, immunosuppression, etc., students should provide a waiver from their health care provider.*

**Are you a foreign-born student?** No_____ Yes_____If yes, what country _____
Have you received the **B.C.G. vaccine**? No_____ Yes_____

**TB Testing:** Have you ever had a positive tuberculosis skin test? No_____ Yes_____
**If yes, attach documentation of date placed, read and reaction in millimeters, chest x-ray, and course of treatment.**

_____ **PPD or Tb skin test (This must be performed within the 180 days prior to your registration date):**

**I certify that all information contained on this form is correct.**

_____ _____
**Student Signature** **Date**