DOMESTIC VISITING STUDENT MEDICAL STATUS FORM

Student's name: ____

To be completed by student:
Do you have any illness that may interfere with your ability to work on a clinical service?
Yes [ ] No [ ] If yes, specify:
____
____

To be completed by the medical provider:

1. **Physical Exam:** within 12 months of school's start. Date: ____________

2. **Screening for Tuberculosis**
   a) **PPD** within **1 year** of the elective's start is required.

   PPD planted Date: month/day/year ________
   PPD read Date: month/day/year ________ Results: _______mm Interpretation: Positive [ ] Negative [ ]

   b) For students with a history of **positive PPD**: Chest x-ray within **6 months** of the elective's start is required.

   Chest x-ray Date: month/day/year________ Interpretation: ________________________________
   Copy of the x ray result must be submitted.

   I attest that the student is free of symptoms: hemoptysis, cough, fever, night sweats, and weight loss.
   Initials of medical provider: _______

3. **Vaccines:**

Measles	Mumps	Rubella	Varicella	Hepatitis B	TdaP*
Measles or MMR Dates: Month/Year 1. 2.	Mumps or MMR Dates: Month/Year 1. 2.	Rubella or MMR Dates: Month/Year 1. 2.	Dates: Month / Year 1. 2.	Dates: Month / Year 1. 2. 3.	Date: Month / Year 1.
If Vaccine record is not available, check titers and complete below					
[] Immune	[] Immune	[]Immune	[]Immune	[]Immune	--------
[]Not immune	[]Not immune	[]Not immune	[]Not immune	[]Not immune	--------

***If Td only was given, the student needs one dose of TdaP.**

In compliance with the New York Health Code, I examined the above student. He/she is free from any health or behavioral issues I attest that the above information is true.

Medical Provider Name: ______________________ **Signature:** _____________________ **Date: month/day/year** ____________

Address/phone/email: ____
Office Stamp: