St. George's University
THINK BEYOND

School of Arts & Science

Admission Date January _______Year_______, August ________ Year_________

Program Entering: A&S Year_______ Pre-Med Year 1_______Pre-Med Year 2________

MPH (Non MD Program) ___________

Other ______________Indicate Program

Any student entering School of Medicine Term1 or School of Veterinary Medicine Term 1 should NOT use this form. You will receive the correct form by email within several weeks of acceptance and deposit. Any questions please email Sconway@sgu.edu

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PART I - HEALTH HISTORY (Complete this part before going to your physician for examination)

Name (Print) ____
Last First Middle

Date of Birth __________________Student ID Number.____

Male ________ Female_______ Home Telephone No.____

E-Mail Address: ____

Home Address____
Number Street

____
City/Town State/Country Zip Code

Person to be notified in case of emergency (Legal Relative):

____
Name Relationship

Home Telephone No. ____________________ Business Telephone No. __________________________

Address____
Number Street

____
City/Town State/ Country Zip Code

PART I - HEALTH HISTORY

Name____

Last First Middle

Answer Yes or No. If the answer to any question below is yes, provide names and addresses of all physicians or healthcare providers who participated in the diagnosis, referral or treatment. Give details, reasons, and dates as appropriate. Please use additional space below or additional pages, if necessary.

A. Has your physical activity been restricted or your education interrupted for medical, surgical or psychiatric reasons during the past five years? Yes______ No ________

____

B. Do you have any physical disabilities or handicaps?

____

C. Have you ever-received treatment or counseling for a psychiatric condition, personality or Character disorder or emotional problem? Yes_______ No______

____

D. Have you had any illness or injury which required treatment or hospitalization by a physician or Surgeon?

Yes______No______

____

D. List any medications you are taking regularly

Name and condition treating: ____

**** It is the student's responsibility to obtain any medications required for use during stay in Grenada.

F. Do you use drugs or substances that alter behavior? (Prescription or non-prescription)

If yes, explain and list condition and MD prescribing

____

G. List any allergies ____

H. Do you have any condition, which requires special consideration or treatment?

____

I declare that I have had no injury; illness or health condition other than specifically noted above and will notify St. George's University of any changes in my health status. I also accept responsibility to obtain any medications I may require for current or future medical, psychiatric treatment.

Date: ____________________ Signature: ______________________________________

PART II - PHYSICAL EXAMINATION

NAME____(Please Print)

To the Examining Physician:
Please review the student's Health History Form and complete applicable parts of the examination form. Please comment on all positive answers using the back of this page or additional pages.

Height _____________Weight_______________ Blood Pressure ____________Pulse______________________
Describe any abnormalities of the following systems in the space below:

Eyes	
ENT	
Neck	
Lungs	
Heart	
Breast	
Abdomen	
Rectum	
Nervous System	
Genitalia	
Extremities	

I have determined that ____is free from any health impairment which is of potential risk to patients or which might interfere with the performance of his/her duties. This includes the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances that may alter the individual's behavior.

_______________________________ Date

____ Signature of Examining Physician

Country or State License #____________________

____ Physician's Name (Please Print)

Address: ____

City:______________________State/Country:________________________Zip Code:___________________

Name: ____________________________________ SGU ID:_______________________________

PART III - IMMUNIZATION RECORD

To be completed and signed by a healthcare provider. All dates should include month and year. Include the manufacturer's name and lot number whenever possible.

A. EVIDENCE OF TUBERCULOSIS SCREENING COMPLETED WITHIN THE 6 MONTHS PRIOR TO REGISTRATION:

1. TUBERCULOSIS SCREENING: Intermediate PPD (5TU Mantoux Test)

Date: ________ Product Name__________________ Lot No: ___________

Result: _______ mm. (Please indicate mm of indurations)

PHYSICIAN/ REGISTERED NURSE SIGNATURE: ____________________________________

License #: _______________________ State/Country: ____________________________

If your PPD is positive (> 10mm) now or by history, the following statement must be signed by a physician and submitted. Students with a history of BCG vaccination or anti-tuberculosis therapy are not excluded from this requirement.

2. I have been asked to evaluate the above named student because of a positive PPD. Based on the student's history, my physical exam and recent chest X-ray, (Date < 6 months_________) I certify that the student is free of active tuberculosis and poses no risk to patients

Physician Signature: ____ Date: ___________________

Print Name: ____

License #___________________________State/Country: _____________________________________

B. MANDATORY REQUIREMENTS:

Please see instructions on the front page. Check boxes where appropriate.

	Date	Signature of Healthcare Provider
1. Measles, mumps, rubella (MMR)		
a. **Two** immunizations at least	MMR#1 ___________	_______________________________
30 days apart	MMR#2 ___________	_______________________________

OR

b. Serum antibody titer to MMR (copy of lab result must be Submitted)		Results	Signature of Healthcare Provider
	Measles IgG	____________	_______________________________
	Mumps IgG	____________	_______________________________
	Rubella IgG	____________	_______________________________

2. Varicella: students may satisfy the requirement for Varicella immunity by providing one of the following:
   A. Physician documentation of disease (i.e., history of "Chicken Pox")
   B. Serum antibody titer to Varicella showing immunity (**copy of lab result must be submitted)**
   C. Immunization: proof of two Varicella vaccines received at least 30 days apart

PART III - IMMUNIZATION RECORD (Continued)

	Date	Signature of Healthcare Provider
3. Tdap (Adecel) Within the last 5 years	________	________________________________

4. Meningococcal Meningitis Vaccine:
   Information regarding this vaccine may be reviewed at www.cdc.gov/ncidod/dbmd/diseaseinfo.

   All entering 1st term students must submit proof of Meningococcal vaccine received < 5 years.

   Date Received:_______________ Physician Signature_______________________________

C. **RECOMMENDED IMMUNIZATIONS (NOT MANDATORY)**:

1. Hepatitis B
Documentation of three doses of hepatitis B vaccine, and a positive hepatitis B surface antibody titer are necessary. Alternatively, a positive hepatitis B core antibody may document immunity. This must be followed with a serology for hepatitis B surface antibody.

	Date	Signature of Healthcare Provider
Hepatitis B Three immunizations at 0, 1 month and 6 months	1. ________	________ ________________________
	2. ________	________________________________
AND	3. ________	________________________________

	Date	Signature of Healthcare Provider
Serum antibody titer (**copy of Lab results must be Submitted**)	________	________________________________
Booster (if necessary)	________	________________________________

Student Name: ____SGU ID #_______________________

2. Hepatitis A

a. Two vaccinations at least 6 months apart 1)___________ 2)___________________

Or | Date | Signature of Healthcare Provider

b. Positive serum antibody titer ________ _______________________________

3.

Polio

a. Completed primary series of polio immunizations

Dates: _________ ____________ ____________

	Date	Signature of Healthcare Provider
b. Booster		
Live vaccine (OPV)	_______	_____________________________
Inactivated (IPV)	_______	______________________________

PART III - IMMUNIZATION RECORD (Continued)

ADDITIONAL IMMUNIZATIONS:

_________________________ Date:_____________ Health Care Provider_____________________

_______________________ Date: ______________Health Care Provider______________________

Date: _____________________ Signature:____

After completion of the Arts & Science Health Form it should be submitted during 1st term registration to the School of Arts& Science. Please make additional copies of complete form to save for future use. No forms will be returned in future.

PLEASE DO NOT SEND TO ADMISSIONS COUNSELOR OR ANY OTHER SGU MEMBER.