MEDICAL EXAMINATION FORM

(INFORMATION CONTAINED HEREIN WILL BE HELD IN CONFIDENCE)

Full Name: _____ Exam Date: _____
Last 4 of SSN: _____ Date of Birth: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: _____ Cell #: _____

All the following information must be provided and/or completed by a health care provider (MD, DO, ARNP, or PA)

Medical History:
Allergies: _____

PATIENT NAME: _____**DOB: _____**

*SHOT RECORDS ARE NOT A SUBSTITUTE FOR TITERS
*NO PHYSICALS OR RECORDS OVER **ONE YEAR** OLD WILL BE ACCEPTED
*TITERS MUST DEMONSTATE IMMUNITY, IF NOT VACCINATIONS/BOOSTERS ARE REQUIRED

Diagnostic Tests/Flu	**Results Date**	**CHECK ONE**	
		Immune	**Not Immune**
Hepatitis B Titer			
Rubella Titer			
Rubeola Titer			
Varicella Titer			
PPD		(negative)	(positive)
Flu Shot (only needed from Sept-Mar)			

(Below are only needed if student does not show immunity to above)

Immunizations	**Date**
Rubella vaccine	
Rubeola vaccine	
Varicella vaccine	
Tdap (only needed if over 10 years)	
*Hepatitis B vaccine *(Hep B vaccine only needed if not immune and has completed series)	

**Chest X-Ray

Classes held on campus

Register online WWW.HCI.EDU
or call (561) 586-0121

$50.00 for the REQUIRED BLS COURSE