American University of the Caribbean
School of Medicine

CLINICAL STUDENT HEALTH STATEMENT

Completion of this form is required for every student participating in clinical rotations with the American University of the Caribbean School of Medicine (AUC). The completed form must be submitted to the AUC Office of Clinical Student Affairs prior to assignment/receipt of a clinical rotation schedule.

Name: _____AUC Student #: _____

Permanent Address: _____

_____

City:_____ State: _____ Zip: _____ DOB: ___/___/___

To be filled out by a health provider:

1. Does this student have any acute/chronic health problems? If yes explain.

_____

_____

2. Date of last physical exam: ___/___/___

Results of the exam: _____

_____

3. PROOF OF IMMUNITY:

	Vaccine Dates			**Titers - MANDATORY** +/-, Count
	1st Date	2nd Date	3rd Date	
Hepatitis B:	___/___/___	___/___/___	___/___/___	_____
Hepatitis C:			(Blood Screen)	_____
Measles:				_____
Mumps:				_____
Rubella:				_____
Varicella:				_____

Tuberculosis: 1st PPD:_____ Results: _____

2nd PPD:_____ Results: _____

(If PPD is positive) Chest X-ray: _____ Results:_____

I verify that the information is true.

_____ _____

Physicians Signature *Date*

Physician's printed Name: _____License # _____

Office Address: _____

City: _____ State:_____ Zip: _____

Telephone: _(_____)_____ E-mail: _____

STATEMENT OF SELF DECLARATION OF FITNESS

I, _____**,** state that I am physically fit and free of habituation or addiction to depressants, stimulants, narcotics, alcohol, and/or other drugs or substances which may alter my behavior or effect my judgment. Any false information, omission, or misrepresentation will constitute reason for release from my association from the assigned hospital site.

Signed: _____ Date: _____