



American University of the Caribbean  
*School of Medicine*

# Student Health Clearance Certificate

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Last, First, Middle)

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Semester:  Winter 20\_\_  Summer 20\_\_  Fall 20\_\_

**All Test Results must be attached with this form.**

## I. Tuberculin Skin Test:

(Mandatory within one year except those with positive skin test history.)

Type of Test: \_\_\_\_\_ Date Tested: \_\_\_\_\_ Date Read: \_\_\_\_\_  
 Positive  Negative

**For those with a history of positive tuberculin test, the following is mandatory:**

Date of last chest X-ray: \_\_\_\_\_

Radiologist X-ray report:  Positive  Negative

## II. HIV Test:

(Mandatory within six months)

Date Tested: \_\_\_\_\_  
 Positive  Negative

(Positive results will not necessarily bar a person from staying in St. Maarten, but will require liaison with the local health authorities.)

## III. Mandatory Proof of Immunity

Hepatitis B: 1st Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ 2nd Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ 3rd Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Hepatitis C: Blood Screen Date: \_\_\_\_\_ Titer Count: \_\_\_\_\_

Measles: Vaccine Date: \_\_\_\_\_ Titer Count: \_\_\_\_\_

Mumps: Vaccine Date: \_\_\_\_\_ Titer Count: \_\_\_\_\_

Rubella: Vaccine Date: \_\_\_\_\_ Titer Count: \_\_\_\_\_

Varicella: Vaccine Date: \_\_\_\_\_ Titer Count: \_\_\_\_\_

Poliomyelitis: Vaccine Date: \_\_\_\_\_ Titer Count: \_\_\_\_\_

Diphtheria: Vaccine Date: \_\_\_\_\_ Titer Count: \_\_\_\_\_

Pertussis: Vaccine Date: \_\_\_\_\_ Titer Count: \_\_\_\_\_

Tetanus: Vaccine Date: \_\_\_\_\_ Titer Count: \_\_\_\_\_

Influenza: Vaccine Date: \_\_\_\_\_ Titer Count: \_\_\_\_\_

## VI. Signatures

### 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: \_\_\_\_\_

Physician's printed Name: \_\_\_\_\_ Licence # \_\_\_\_\_

Office Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Country: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

### I verify that the information is true.

Signature of Physician: \_\_\_\_\_ Date \_\_\_\_\_

### 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 of effect my judgement. Any false information, omission, or misrepresentation will constitute grounds for dismissal from the University.

Signature of Student: \_\_\_\_\_ Date \_\_\_\_\_

Verified by AUC Official: \_\_\_\_\_ Date \_\_\_\_\_

*Note: Students are required to enroll in the AUC health insurance policy underwritten by Monumental Life, unless they have proof of existing comparable global health insurance coverage. This is a requirement to receive a student visa from the government of St. Maarten.*

### Please return Student Health Clearance Certificate to:

**Medical Education Administrative Services, 901 Ponce de Leon Blvd., Suite 700, Coral Gables, Florida 33134**