



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 and must be updated every 12 months. Results must be written in English. Please note that some hospital sites may require additional testing and/or vaccinations.

Name: _____ AUC Student #: _____ DOB: ___/___/___

Permanent Address: _____

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: ___/___/___ Exam Results: _____

3. PROOF OF IMMUNITY:

Vaccine Dates

Titer Value
(Must provide lab report)

	1 st Date	2 nd Date	3 rd Date	+/-, Count
Hepatitis B:	___/___/___	___/___/___	___/___/___	_____
Hepatitis C:			(Blood Screen)	_____
Measles:				_____
Mumps:				_____
Rubella:				_____
Varicella:				_____
Influenza:			(Date of Injection)	_____
Tuberculosis:	1 st PPD date: _____		Results: _____	
	2 nd PPD date: _____		Results: _____	
	Chest X-ray date: _____		Results: _____	
	<i>(must show proof of positive PPD)</i>			

I verify that the information provided above is true.

Physician's printed name: _____ License # _____

Physician's signature: _____

Office Address: _____

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.

Student Signature: _____ **Date:** _____