American University of the Caribbean School of Medicine

STUDENT HEALTH CLEARANCE CERTIFICATE

PLEASE RETURN FORM TO:

American University of the Caribbean School of Medicine Attention, Office of Admission
10315 USA Today Way, Miramar, Florida, 33025

STUDENT INFORMATION

Full Name: ____________________

Address: ____________________

City/State/Zip: ____________________

Email: ____________________ Date: ___ / ___ /___

Semester you will be attending: Jan 20 ________ May 20 ________ Sept 20 ________

TO BE COMPLETED BY A QUALIFIED HEALTH CARE PROVIDER AND WITH LAB REPORTS ATTACHED:

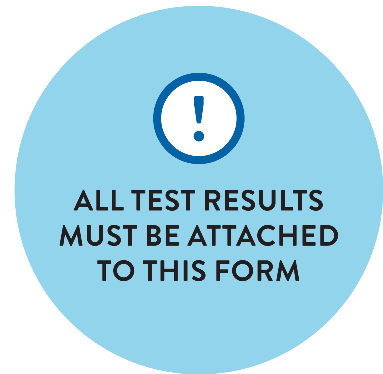
Does this student have any acute/chronic health problems? If yes, please explain:

____

____

Date of last physical exam: ___ / ___ /___ Exam results: ____________________

Proof of immunity	Titer Value	Vaccine Date(s)
Measles	________	___ / ___ /___
Mumps	________	___ / ___ /___
Rubella	________	___ / ___ /___
Varicella	________	___ / ___ /___
Diphtheria	________	___ / ___ /___
Pertussis	________	___ / ___ /___
Tetanus	________	___ / ___ /___
Poliomyelitis	________	___ / ___ /___
Influenza	________	___ / ___ /___



Results of specific tests:

A. Hepatitis C antibody Positive Negative Date: ___ / ___ /___

B. Tuberculosis PPD: Positive Negative Date Read: ___ / ___ /___

If positive PPD, chest x-ray results: ________________ Date Read: ___ / ___ /___

Hepatitis B:

A. Hepatitis B immunization series dates: 1st: ___ / ___ /___ 2nd: ___ / ___ /___ 3rd: ___ / ___ /___

B. Hepatitis B surface antibody (HepBsAb) titer: ________________* Date: ___ / ___ /___

C. Hepatitis B core antibody (HepBcAb): Positive Negative Date: ___ / ___ /___

D. Hepatitis B core antigen (HepBsAg): Positive Negative Date: ___ / ___ /___

* If HepBsAb titer is low or not strongly positive and HepBcAb and HepBsAg are both negative, then (re)vaccination against hepatitis B is suggested.
If HepBsAb, HepBcAb, and HepBsAg are all negative, then (re)vaccination against hepatitis B is mandatory.

OFFICE OF ADMISSIONS
10315 USA Today Way, Miramar, Florida, 33025 | **Phone:** 305-446-0600 | **Fax:** 786-433-0974 | admissions@aucmed.edu | aucmed.edu

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COVID-19 VACCINATION

AUC students are required to be fully vaccinated against COVID-19 by receiving all doses of a vaccine (including 2 doses for Pfizer-BioNTech, Oxford-AstraZeneca, Moderna, Sinopharm-BBIBP, and CoronaVac; 1 dose for Johnson & Johnson).

First vaccination:

Date: ___ / ___ /___ Name of Vaccination: ______________________________

Second vaccination (if applicable):

Date: ___ / ___ /___ Name of Vaccination: ______________________________

A copy of your COVID-19 vaccination record must be attached to this form.

I VERIFY THAT THE INFORMATION PROVIDED IS TRUE

Health Care Provider's Printed Name: ______________________________ License #: ______________

Office Address: ______________________________

City: ______________________________ State: ______________ Zip Code: ______________

Country: ______________________________

Phone: ______________________________ Email: ______________________________

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 or affect my judgment. Any false information, omission, or misrepresentation will constitute grounds for dismissal from AUC.

Signature of Student: ______________________________ Date: ___ / ___ /___

Verified by AUC Official: ______________________________ Date: ___ / ___ /___

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