Health History, Physical Examination, Certificate of Immunization, and Tuberculosis Testing Results

The following forms are to be completed and signed by the student and/or a physician or other healthcare provider as indicated on the forms.

Return the completed forms directly to the Clinical Team at the Ratho Mill Campus on St. Vincent and bring the original documents with you to campus.
Submit forms using the **Student Health Documents Submittal Form** (https://form.jotform.com/53418793839976)
Any questions pertaining to these forms or other health questions should be sent to Dr. Mignonette Sotto at: ***msotto@trinityschoolofmedicine.org*** or Dr. Jack-Edwards at ***fjack@trinityschoolofmedicine.org***

Prior to the first term of enrollment, students must have a physical examination and must provide Trinity School of Medicine with a health history, documented proof of immunity to certain contagious diseases, and results of a tuberculosis skin test. A physician must conduct the physical examination, and a physician or other healthcare provider must sign the Certificate of Immunization and the Tuberculosis Test Results.

The Certificate of Immunization form contains the list of diseases for which documentation of immunity is required. Please note that documentation of lab results (true copy of lab results) is required.

Health History

Complete all sections, sign the appropriate statement in Section IV, and return the Health History form to Trinity School of Medicine using the **Student Health Documents Submittal Form**

Physical Examination Form

Complete Part A and have your physician complete and record the findings/results of your physical examination on the Physical Exam form.

Certificate of Immunization

Complete Part A and have your physician or other health care provider complete Part B. Any request for an exemption from immunization requirements must have signed documentation attached.

Tuberculosis Testing Results

Complete Part A and have your physician or other health care provider complete Part B. Two options for tuberculosis testing are available:

1. Tuberculin Skin Test (TST)
2. An FDA approved blood test for tuberculosis

A positive result from either testing option requires a follow-up chest x-ray, x-ray report, and a statement from your physician that you are free from any communicable disease.

Additional Information

Questions regarding Trinity School of Medicine policies and requirements for health history, documentation of immunizations, physical examination, and tuberculosis testing should be directed to: Dr. Mignonette Sotto ***msotto@trinityschoolofmedicine.org*** or Dr. Jack-Edwards ***fjack@trinityschoolofmedicine.org***

TRINITY
SCHOOL OF MEDICINE

Health History – REQUIRED

Please submit forms using the Student Health Documents Submittal Form.
Questions should be sent to Dr. Mignonette Sotto *msotto@trinityschoolofmedicine.org* or
Dr. Jack-Edwards *fjack@trinityschoolofmedicine.org*

Complete all sections and sign the appropriate statement in Part D: Authorization to Treat.

Part A: Student Information

Name:		Date of birth:	
Phone:	Email Address:		
School Use Only - TSOM Student ID:			

Part B: Permanent Address information, E-mail, and Phone

Street Address: _____

City/State/Country/ZIP: _____

Telephone Number: (_____) _____ Semester/Year of First Enrollment _____

Permanent E-mail: _____

Part C: Health Information

The following information is strictly for the purpose of assisting Student Health in caring for you while you are attending Trinity School of Medicine. It is not used as a criterion for admission and will not be released to anyone without your written consent.

ALLERGIES	No	Yes	If yes, please give specific details.
Drugs	○	○	_____
Pollen	○	○	_____
Food	○	○	_____
Insect	○	○	_____
Other	○	○	_____

HOSPITALIZATION

Have you ever been hospitalized? Yes ○ No ○ If yes, please list date(s) and reason(s) for hospitalization(s):

_____ _____

_____ _____

_____ _____

_____ _____

MEDICATION

Are you currently taking medication? Yes ○ No ○

If yes, please list the medication(s) _____

_____

IMPORTANT NOTE: Persons taking controlled medications and engaged in international travel should obtain a letter from the prescribing physician on the physician's letterhead/stationery confirming that the controlled substance has been prescribed by the physician; keep this letter with your medication.

MEDICAL CONDITION

Do you have a chronic (long-lasting or persistent) medical condition that requires treatment or medication? Yes ○ No ○

If YES, please have your physician provide a summary of your treatment that includes the following:

- Condition being treated
- Type of medication
- Physician's address and phone number

Please have physician summary sent to: Student Health Records using the Please submit forms using the **Student Health Documents Submittal Form**

Part D: Authorization to Treat

AUTHORIZATION TO TREAT *If you are over 18 years of age*

I hereby authorize the physicians of Student Health and their agents or consultants, including those at area hospitals, to perform diagnostic and treatment procedures which in their judgment may become necessary while I am at Trinity School of Medicine.

Signature _____ Date _____

AUTHORIZATION TO TREAT *If you are under 18 years of age*

I hereby authorize the physicians of Student Health and their agents or consultants, including those at area hospitals, to perform diagnostic and treatment procedures on the above named student which in their judgment may become necessary while she/he attends Trinity School of Medicine. I waive all claims to prior notification. I understand that every effort will be made to notify me in the event of a major illness or injury, or if the Student Health Services physician feels it is necessary.

Signature of parent/guardian _____ Date _____

Part E: Emergency Contact Information

Name: _____ Relationship: _____
Address: _____
_____
Daytime Phone: (_____) _____ Nighttime Phone: (_____) _____
E-mail Address: (if any) _____

Name: _____ Relationship: _____
Address: _____
_____
Daytime Phone: (_____) _____ Nighttime Phone: (_____) _____
E-mail Address: (if any) _____

Part F: Medical Insurance Information

Important: All Trinity School of Medicine students must have health insurance. If you are covered by a health insurance policy, complete this part of the Health History form. Students who do not provide documentation of health insurance will be enrolled in the student health insurance program provided by the institution and the premium for the insurance policy will be added to the student's invoice for tuition, fees, and other charges. If you have not been contacted by the School Insurance Provider, please place "Trinity Health Insurance Program" on the "Insurance Company Name:" line.

Insurance Company Name: _____
Address: _____
_____
_____
Policy No.: _____
Group No.: _____
Identification No.: _____

Physical Examination – REQUIRED

Please submit forms using the Student Health Documents Submittal Form.
Questions should be sent to Dr. Mignonette Sotto *msotto@trinityschoolofmedicine.org* or
Dr. Jack-Edwards *fjack@trinityschoolofmedicine.org*

Part A: Student Information (To be completed by student)			
Name:		Date of birth:	
Phone:	Email Address:		
School Use Only - TSOM Student ID:			

Part B: Patient Examination (To be completed by physician)

Height: _____ Blood Pressure: _____

Weight: _____ Pulse: _____

Any known allergies? Yes ○ No ○

If yes, please describe: _____

_____

HEENT: _____ Genitalia: _____

Chest: _____ Mental Status: _____

Abdomen: _____ Extremities: _____

Heart: _____ Other: _____

Blood Type and RH Factor (optional) : _____

HIV Test (optional): _____ Date performed: _____

Communicable Diseases

This individual is free of communicable diseases: Yes ○ No ○

If NO, please attach a statement describing the illness and treatment plan.

Part C: Physician Name and Signature

Physician's Name (printed): _____ Phone number: _____

Address: _____

_____

Physician Signature: _____ Exam date: _____

CERTIFICATE OF IMMUNIZATION – REQUIRED

Please submit forms using the Student Health Documents Submittal Form.
Questions should be sent to Dr. Mignonette Sotto *msotto@trinityschoolofmedicine.org* or
Dr. Jack-Edwards *fjack@trinityschoolofmedicine.org*

Part A: Student Information (to be completed by student):

Name:		Date of birth:	
Phone:	Email Address:		
School Use Only - TSOM Student ID:			

Part B: Immunization Information (to be completed by physician or health care provider), also provide a copy of your immunization record:

REQUIRED IMMUNIZATIONS	REQUIREMENT	DATES (titer)	REQUIRED FOR:
MMR (Measles, Mumps, Rubella) combined shot	Documentation of lab evidence (titer) of immunity to each disease. True copy of lab report must be attached.	___/___/___	Students born after 1956
---------- OR ----------	---------- OR ----------	----------	----------
Measles (Rubeola)	Documentation of lab evidence (titer) of immunity to disease. True copy of lab report must be attached.	___/___/___	Students born after 1956
and	And		
Mumps	Documentation of lab evidence (titer) of immunity to disease. True copy of lab report must be attached.	___/___/___	Students born after 1956
and	And		
Rubella (German measles)	Documentation of lab evidence (titer) of immunity to disease. True copy of lab report must be attached.	___/___/___	All students
Varicella (chicken pox)	Documentation of lab evidence (titer) of immunity to disease. True copy of lab report must be attached.	___/___/___	All US born students born in 1980 or later and all foreign born students regardless of year born
Tetanus and Diphtheria (Td or Tdap*) * Tetanus, diphtheria, acellular pertussis	Td or Tdap	___/___/___ ___/___/___	All students must have one dose within 10 years
Hepatitis B	Documentation of lab evidence (titer) of immunity to disease; positive HbsAb (Hepatitis B antibody) titer. True copy of lab report must be attached.	___/___/___	All students
Polio	❑ 2 doses of IPV or ❑ 1 dose adult IPV booster (For persons who received Oral Polio Vaccine as a child)	#1 ___/___/___ #2 ___/___/___ ___/___/___	All students

Optional Immunizations

Hepatitis A	2 doses	#1 ___/___/___	#2 ___/___/___			
Influenza	1 dose	___/___/___				
Meningococcal (meningitis)	1 dose	___/___/___				
Human papillomavirus (females only)	3 doses	#1 ___/___/___	#2 ___/___/___	#3 ___/___/___		

Request for Exemption

❑ Temporary medical exemption until: ___/___/___ *Attach verification by physician*	❑ Permanent medical exemption *Attach verification by physician*	❑ Religious exemption *Attach verification by religious leader*

Required signature of physician or health facility

Name: _____ Address: _____
Signature: _____ _____
Date: _____ Phone: _____

Tuberculosis Testing Results – REQUIRED

Please submit forms using the Student Health Documents Submittal Form.
Questions should be sent to Dr. Mignonette Sotto *msotto@trinityschoolofmedicine.org* or
Dr. Jack-Edwards *fjack@trinityschoolofmedicine.org*

Part A: Student Information (to be completed by student):			
Name:		Date of birth:	
Phone:	Email Address:		
School Use Only - TSOM Student ID:			

Part B: Tuberculosis Testing Requirement and Test Results (to be completed by physician or health care provider):

Requirement: Each student must be tested for tuberculosis prior to initial enrollment. In instances where the student has previous positive TST or was vaccinated for BCG, option 2 is recommended.

Option 1: A Tuberculin Skin Test (TST) (the MANTOUX skin test) no more than 3 months prior to the beginning of classes. Results must be recorded in millimeters (mm) of induration, transverse diameter. If no induration, write "0".

Option 2: IGRA test either Tspot or Quantiferon.

NOTE: Documentation of BCG vaccine does not preclude testing; testing for tuberculosis is required of all students.

Option 1: Tuberculin Skin Test (TST)

Date given ____/____/____ (MM/DD/YY) Date Read____/____/____ (MM/DD/YY)

Results: ____ mm (Record actual millimeters of induration, transverse diameter. If no induration, record as "0 mm.")

Option 2: Blood test (must be a test approved for use by the US Food and Drug Administration)

Name of test: _____ Date of test ____/____/____ (MM/DD/YY)

Results: ❑ Negative ❑ Positive

REQUIRED FOLLOW-UP FOR POSITIVE TEST RESULTS
Chest X-Ray and Physician Statement are required if test results are positive.

Date of chest x-ray: ____/____/____ (MM/DD/YY)

Result: _____ Normal _____ Abnormal (If result is abnormal, include copy of chest x-ray report in English and signed by physician)

A signed statement from the physician that the student does not have a communicable disease or infection is required if the student has a positive test result or a history of a positive test results. The physician's statement must accompany this Tuberculosis Testing Result report.

Required signature:

Name (printed): _____ Phone: _____

Address: _____

_____

Signature: _____ Date: _____

N OTE: The report must be signed by a physician if results are determined to be positive.