Vaccination Policy

Prior to attending the required internship, all students must submit the attached vaccination documentation.

ALLEN SCHOOL
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of Health Sciences

"Where Education Comes To Life"

ALL ENTRIES MUST BE MADE IN FULL OR THE PHYSICAL IS NOT ACCEPTED. PLEASE PRINT ALL INFORMATION, OFFICIAL STAMP REQUIRED

NAME: _____ **SEX:**____ **DOB:**__/__/__**AGE:** _____ **SSN:** _____
ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____
PHONE: _____ **PROGRAM: Medical Assisting [ ] Nursing Assistant [ ]**

1. Previous Medical Illness/Disease: _____
2. Current Medications(s): _____
3. Allergies: _____
4. Last Menstrual Period: _____

HABITS:

1. Cigarette Smoking: _____
2. Alcohol Drinking: _____
3. Drug Addiction: Depressants: _____ Stimulants: _____ Narcotics: _____ Other: _____

MEDICAL TESTS: A COPY OF ALL BLOOD WORK MUST BE ATTACHED

P.P.D. Date Given: _____ Date Read: _____ RESULT: Negative ____ Positive ____

Chest X-Ray Date (If positive history and last x-ray is greater than 2 years old).
Done: _____ Results: _____

MMR Titer Date Drawn: _____ Results: Immune_____ Nonimmune _____
Ratio: Measles:_____ Mumps:_____ Rubella:_____

Rubeola Titer Date Drawn: _____ Results: Immune _____ Nonimmune _____
Ratio: _____

Tetanus Date of Last Booster: _____ (must be within 10 years)

Hepatitis B Date of last Booster/Immunization:_____
Drawn: _____ Results: Immune_____ Nonimmune _____

Varicella (Only if you never had Chicken Pox): _____

Nursing Assistant's ONLY: Influenza vaccination required during flu season

PHYSICAL EXAMINATION – REVIEW OF SYSTEMS:

	Normal	Abnormal	Comment(s)
Head:	( )	( )	_____
ENT:	( )	( )	_____
Neck:	( )	( )	_____
Heart:	( )	( )	_____
Lungs:	( )	( )	_____
Abdomen:	( )	( )	_____
Back:	( )	( )	_____
Skin:	( )	( )	_____
Extremities:	( )	( )	_____

VITALS:
Height: _____
Weight: _____
BP: _____
Pulse: _____
Resp: _____

ARE THERE ANY PHYSICAL LIMITATIONS THAT MIGHT PREVENT THIS STUDENT FROM COMPLETING HIS/HER INTERSHIP PROGRAM? Yes _____ No _____
IF YES, PLEASE DESCRIBE: _____

OVERALL IMPRESSION (DOCTOR MUST WRITE IMPRESSION): _____

_____ _____
DATE DOCTOR'S SIGNATURE, STAMP, LICENSE#