LU COLLEGE of PHARMACY
Changing Lives

Enrollment Physical Exam Form

_____ _____
Student Name (PRINT) Date of Birth

Based on review of the patient's medical history and physical exam, it is my professional opinion that the above student is in satisfactory health to participate in required activities as part of the Larkin University College of Pharmacy curriculum and rotations, which will take place in various health care settings such as community pharmacies and hospitals.

Please note that rotations may have site specific requirements (e.g., drug screens, fingerprints, background check, etc.) not covered by this form. In order to participate in rotations, matriculated students are required complete these and other pre-rotation requirements as instructed by the Office of Experiential Education.

Healthcare Provider Name (PRINT) _____ Date_____/____/_____

Healthcare Provider Signature _____

Facility Name & Address

_____

_____

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Enrollment Immunization Form

_____ _____

Student Name (PRINT) Date of Birth

MEASLES, MUMPS, and RUBELLA (MMR) *Provide documentation of either dosage series OR serologic immunity

Option 1:

MMR Dose #1 Date Given _____/_____/____

MMR Dose #2 Date Given _____/_____/_____

Option 2: Serologic immunity to each of the 3 diseases ***(laboratory results must be attached)***

Measles titer Date Performed_____/____/_____Immune? Yes NO

Mumps titer Date Performed_____/____/_____Immune? Yes NO

Rubella titer Date Performed_____/____/_____Immune? Yes NO

TETANUS-DIPTHERIA-PERTUSSIS

Tetanus/ Diphtheria/Pertussis (Tdap) Tetanus/Diphtheria Date Given _____/____/_

(Td) Booster (if ≥ 10 years since Tdap) Date Given_____/____/_____

Healthcare personnel are required to receive a single dose to Tdap as soon as feasible if they have not previously received Tdap and regardless of the time since their most recent Td vaccination. Following Tdap vaccination, routine Td booster shots must be received every 10 years.

VARICELLA (Chicken Pox) *Provide documentation of either dosage series OR serologic immunity

Option 1:

Varicella Dose #1 Date Given_____/____/_____

Varicella Dose #2 Date Given_____/____/_____

Option 2: Serologic immunity ***(laboratory results must be attached)***

Varicella IgG Antibody titer Date Performed____/____/_____ Immune? Yes_____NO _____

A medical history of "chicken pox" is NOT sufficient evidence to support immunity.

HEPATITIS B (Hep B) *Proceed with all doses PRIOR to completing the titer

Step 1:

Hep B Dose #1 Date Given_____/____/_____

Hep B Dose #2 Date Given_____/____/_____

Hep B Dose #3 Date Given_____/____/_____

Step 2: Serologic immunity done 1-2 months **AFTER** administration *of* the last dose of the hepatitis B vaccine series ***(laboratory results must be attached)***

Hep B Surface Antibody titer Date Performed____/____/_____ Immune? Yes_____NO _____

Post vaccination serologic testing is required for all healthcare personnel at high risk for occupation percutaneous or mucosal exposure to blood or body fluids.

I certify that the information above is complete and accurate to the best of my knowledge

Healthcare Provider Name (PRINT) _____ Date_____/_____/_____

Healthcare Provider Signature _____

Facility Name & Address _____

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Two Step PPD Skin Test Form

FORM IS DUE AT ENROLLMENT BETWEEN JUNE 3rd – JULY 22nd

Enrollment PPD skin test must be administered during date range noted above and requires both step one and step two.

Student Name (PRINT) _____ Date of Birth _____

STEP ONE:	**STEP TWO**: (must be at least 7 days from step one PPD)
Date baseline skin test read: _____/_____/ _____	Date Skin test read: _____/_____/ _____
Result: Positive?_____Negative? _____	Result Positive?_____Negative? _____

If the above tests return with a positive result, a chest x-ray must be performed. An annual TB clearance letter needs to state no signs and symptoms of tuberculosis. Documentation of a positive PPD result must occur **PRIOR** to performing the chest x-ray.

Chest X-Ray *(copy of chest x-ray must be attached).*
Date of chest x-ray_____/_____/ _____
Result Positive?_____Negative? _____

I certify that the information above is complete and accurate to the best of my knowledge

Healthcare Provider Name (PRINT) _____ Date_____/____/_____

Healthcare Provider Signature _____

Facility Name & Address _____