

SCHOOL OF MIDWIFERY AND CHILD HEALTH

HEALTH QUESTIONNAIRE FOR VISITING STUDENTS

Name: _____ **DOB:** _____

School/Department: _____

TO THE HEALTH PROVIDER

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

a. Is the student currently taking any prescription medications?

b. Does the student have any special dietary needs? Please specify:

c. Does the student have any allergies to food or medicine? Please specify:

2. Date of last physical exam (must be no more than one year prior to visit):

Result of exam:

3. PROOF OF IMMUNITY TO MEASLES, MUMPS AND RUBELLA IS REQUIRED. ONE DOSE OF LIVE MUMPS AND RUBELLA VACCINES AFTER FIRST BIRTHDAY, TWO DOSES OF LIVE MEASLES VACCINE AFTER FIRST BIRTHDAY, OR IMMUNE TITRES WILL SATISFY THE REQUIREMENT.

Measles vaccine: _____ or titre _____
No.1 date No.2 date

Mumps vaccine: _____ or titre _____
Date

Rubella vaccine: _____ or titre _____

4. FOR ANY STUDENT WORKING WITH BLOOD OR BODY TISSUES OR HAVING DIRECT PATIENT CONTACT THE FOLLOWING IS REQUIRED: Not required for students from the State University of New York Downstate Medical Center, United States.

Hepatitis B Surface Antigen and Antibodies: _____

Date of 5 Year booster: _____

Hepatitis C Antibodies: _____

HIV Antibodies: _____

5. HISTORY OF CHICKEN POX/VARICELLA? Yes: _____ No:-----

If no, Varicella vaccine: _____

No.1 date

No. 2 date

6. TUBERCULIN TEST (If known negative, Mantoux test must be administered within six months prior to elective).

Date of Last Test: _____ Result: _____mm induration

Chest X-ray (required if Mantoux Test positive):

Date: _____ Result: _____

I certify that the above statements are true.

Signature of Health Care Provider: _____

Address: _____

Telephone Number: _____