Health Certificate and Vaccination

Inter-American University of Puerto Rico
School of Optometry
500 John Will Harris
Bayamón, PR 00957
Admissions: (787) 765-1915 Ext 1020 Admissions Fax: (787) 756-7351
Admissions email: admissions@inter.edu

Name *(Last, First, M.I.)*: ☐ M ☐ F	**Date of Birth:**
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PREVIOUS HISTORY OF IMMUNIZATION

Vaccination	☐ DTP	Comments:
	☐ MMR	Comments:
	☐ OPV	Comments:
	Hepatitis Vaccine (*Indicate Dates*) ☐ 1st shot ____________ ☐ 2nd shot ____________ ☐ 3rd shot ____________	

After thorough physical examination and evaluation of laboratory results which includes:

PPD(Mantoux): Date Given: __________ Date Read: __________ Results: _____mm

Chest x-ray (*if skin test is positive*) Date: __________ Results: ___________

VDRL: Non-Reactive ______________ Reactive ______________

HEALTH CARE PROFESSIONAL DETAILS & DECLARATION

I certify that I have seen the above student and the information I have supplied is true and correct.

________________________________ ________________
Physician Signature Date

________________________________ ________________
Name of Physician License State and Number

____________________________________ ______________ ________________ ______________
Address City State Zip Code