Health Certificate and Vaccination

Inter-American University of Puerto Rico
School of Optometry
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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