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 or IPV	Comments:
	Hepatitis B 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