American University of the Caribbean
School of Medicine

STUDENT HEALTH CLEARANCE CERTIFICATE

Name (last, first, middle) ____ Phone:__________________________

Address:____ City:____

State: ________ Zip: _________________ Email:____

DOB: ___/___/___ Student ID:_____________ Semester/Year: January 20____ May 20____ September 20____

To be completed by a qualified health care provider and with lab reports attached:

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

   ____

   ____

2. Date of last physical exam: ___/___/___ Exam results:____

3. Proof of immunity:

	Titre Value:	Vaccine Date(s):
Measles	_____________	___/___/___
Mumps	_____________	___/___/___
Rubella	_____________	___/___/___
Varicella	_____________	___/___/___
Diphtheria	_____________	___/___/___
Pertussis	_____________	___/___/___
Tetanus	_____________	___/___/___
Poliomyelitis	_____________	___/___/___
Influenza		___/___/___

4. Results of specific tests:

	Status:	Date:
a. Hepatitis C antibody	positive/negative	___/___/___
b. Tuberculosis	PPD: positive/negative	Date read: ___/___/___
If positive PPD, chest x-ray	Results: ______________________________	Date read: ___/___/___

5. Hepatitis B:

	Status:	Date:
a. Hepatitis B immunization series	1st___/___/___ 2nd ___/___/___ 3rd___/___/___	
b. Hep B surface antibody (HepBsAb) titre	_____________*	___/___/___
c. Hepatitis B core antibody (HepBcAb)	positive/negative	___/___/___
d. Hepatitis B surface antigen (HepBsAg)	positive/negative	___/___/___

***If HepBSAb titre is low or not strongly positive and HepBcAb and HepBsAg are both negative, then (re)vaccination against hepatitis B is suggested.**

If HepBSAb, HepBcAb, and HepBsAg are all negative, then (re)vaccination against hepatitis B is mandatory.

(Revised version January 2016)

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I VERIFY THAT THE INFORMATION PROVIDED IS TRUE.

Heath care provider's printed name: ____

License #: ______________

Health care provider's signature:

____

Office address: ____ State:______ Zip Code:_________________

Phone:_____________________________________ Email: ______________________________________

STATEMENT OF SELF-DECLARATION OF FITNESS:

I,_________________________ ,state that I am physically fit and free of habituation or addiction to depressants, stimulants, narcotics, alcohol, and/or other drugs or substances which may alter my behavior or affect my judgement. Any false information, omission, or misrepresentation may constitute grounds for dismissal from AUC and, if enrolled in clinical rotations, reason for release from my association to the assigned hospital.

Student signature: ____ Date:_______________________

Verified by AUC Official: ____ Date:_______________________

Please return this certificate, once completed, to:

The Office of Clinical Student Affairs (OCSA)
American University of the Caribbean School of Medicine
901 Ponce de Leon Blvd, Suite 700
Coral Gables, Florida, 33134

(Revised version January 2016)