MEDICAL EXAMINATION REPORT FORM

STEIN ACADEMY

3610 Milford Mill Rd.

Baltimore, Maryland 21244

Tel: 410-922-4910 Fax: (410) 922-3636

PART A*: To be completed by student*

Name of Student:_____Program:_____

I, _____, authorize medical information provided by my Primary Care Provider to be released to Stein Academy.

Are you pregnant? _____YES _____NO

Signed:_____Date:_____

PART B*: To be completed by Primary care provider* REQUIRED TO BEGIN THE PROGRAM

(1a) History and Physical completed by:

Name of Primary Care provider:_____Date:_____

The above student is in satisfactory physical condition.

_____YES _____NO Please explain if the answer is No

_____

_____

_____

(1b) If the student checked YES for PREGNANCY in section A above, is she able to do Clinical/Externship?
_____ YES _____NO

(2) PPD Date:_____Result:_____
Student is Free from TB or other communicable disease which might present a health hazard to patients or other personnel. _____YES _____NO. If No, Please Explain: _____

_____

(3) MMR Date Taken:_____ **(4) Varicella** Date Taken:_____

(5) Hepatitis B: Date of 1st vaccine _____ Date of 2nd vaccine _____ Date of 3rd vaccine _____Hep B titer: Date given:_____

Primary Care Provider

_____ Signature:_____Date:_____
Print Name

Address: _____ Place Seal or Stamp

Please Mail or Fax Report to:

Stein Academy

3610 Milford Mill Rd.

Baltimore, MD 21244; Fax: 410-922-3636