**BLUFFTON UNIVERSITY DIETETIC INTERN MEDICAL HISTORY/HEALTH FORM**

*Please print in ink and complete both sides with health care provider and intern signatures.*

Name:________________________________________________ Birthdate: _____/______/______

Home Address: ______________________________________________________________________

City or Town, State Zip Code:_______________________________________________________

Telephone: (_____) _____________ E-mail address: __________________________________

**Person to contact in case of EMERGENCY:**

Name: ___________________________________________ Relationship: ________________________

Address: ___________________________________________________________________________________

City or Town, State Zip Code:_______________________________________________________________

Home/Cell Phone Number (____)___________ Work Phone Number: (_____)_____________

**IMMUNIZATION RECORD**

**IMMUNIZATIONS LISTED are REQUIRED FOR ALL INTERNS**

**TETANUS / DIPHTHERIA/ PERTUSSIS (TDaP)** Booster within the last 10 years

Date: _____/_____/_____

**MEASLES, MUMPS, RUBELLA (MMR)** (two dose series)*

Dose #1:____/_____/_____ and Dose #2: ____/____/_____

*OR Blood test (titer) showing immunity to each disease (MUST attach lab results).

**VARICELLA** (two doses required after age 12)*

Dose #1:____/____/_____ and Dose #2: ____/____/_____

**HEPATITIS B** (three-dose series)

Dose #1: ____/____/_____ Dose #2: ____/____/_____ Dose #3____/____/_____

**ANNUAL INFLUENZA VACCINE** Note - flu vaccines are required for hospital-based clinical experiences and may be received after the start of the internship year and verified by the Experience Coordinator. **If intern cannot receive flu shot for some reason please explain:**

Date influenza vaccine received: ___/___/______ Exp. Coordinator Initials:________

**DIETETIC INTERNS: are REQUIRED TO RECEIVE the Mantoux tuberculin skin test (TST) AFTER JUNE 1 of the current year, unless a previous positive test has been documented:**

**Tuberculin Skin Test (TST)**
(TST result should be recorded as actual millimeters (mm) of induration , transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)

Date Given: ____/____/________ Date Read: ____/____/________

Result: _________ mm of induration Interpretation: positive _____ negative _____

**Chest x-ray: (Required if - TST is positive)**
Date of chest x-ray: ____/____/________ Result: normal _____ abnormal _____

**HEALTH CARE PROVIDER giving TB screening**
Name ______________________________________________Title ___________________________
Signature________________________________________ (if different from health care provider below)
Address _____________________________________________________
Phone(_____)__________________________________________________

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**MEDICATION/FOOD/OTHER Allergies** (please add page if necessary):
_____________________________________________________________________________________
_____________________________________________________________________________________

**CURRENT MEDICATIONS** and reason for use (please add page as needed):
_____________________________________________________________________________________
_____________________________________________________________________________________

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**CURRENT ILLNESSES/DISABILITIES/HEALTH RESTRICTIONS:**
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**To the best of my knowledge, the information submitted is complete and accurate and may be used for educational and clinical experiences as required. This student is fit for participation in food service and clinical supervised practice experiences at this time.** The information above regarding intern vaccination status is accurate and is being provided in compliance with the Ohio Revised Code, Section 3701.133, (B).

**Signature (Intern)** __________________________________________________ **Date**________

**Signature (Physician)**_______________________________________________ **Date**________