

**California State University, Long Beach  
Department of Nursing  
Health Exam for Entering Students**

<b>Last Name:</b>	<b>First:</b>	<b>MI:</b>	<b>DOB:</b>
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**Health History: Please attach a lab copy of all titers and proof of immunizations. Student should keep originals.**

Procedure			
<b>TB Skin Test (PPD/Mantoux)</b>	Date:	Negative:	Positive
<b>Positive PPD requires chest x-ray every 4 yrs</b>	Date:	Result:	

Procedure	Date	Results of Titers ONLY
<b>Varicella Vaccination and</b>		
<b>*Varicella IgG Quantitative Titer</b>		Immune <input type="checkbox"/> Not immune <input type="checkbox"/>
<b>T.DaP</b> (Within past 10 years)		
<b>MMR Vaccination and</b>		
<b>*Rubeola IgG Quantitative Titer</b> And		Immune <input type="checkbox"/> Not immune <input type="checkbox"/>
<b>*Rubella IgG Quantitative Titer</b> And		Immune <input type="checkbox"/> Not immune <input type="checkbox"/>
<b>*Mumps IgG Quantitative Titer</b>		Immune <input type="checkbox"/> Not immune <input type="checkbox"/>
<b>Hepatitis B Virus</b> (HBV Series-Last 3 dates) <b>and</b>	1. 2. 3.	
<b>*HbsAb Quantitative Titer</b>		Immune <input type="checkbox"/> Not immune <input type="checkbox"/>
<b>Annual Flu Shot</b>		

**Physical Exam Date:** \_\_\_\_\_  
**History of back problems/restrictions on lifting: Yes** \_\_\_\_\_ **No** \_\_\_\_\_  
**If yes, please explain, including how many pounds student can lift:**  
 \_\_\_\_\_

**I hereby certify that I have examined the above named student and the student is in good mental and physical condition. If any restrictions exist and accommodations are requested, please list them below:**  
 \_\_\_\_\_  
 \_\_\_\_\_

**Signature of Health Care Provider:** \_\_\_\_\_  
**Stamp with Physician Address**  
 \_\_\_\_\_

