

ANGELO STATE UNIVERSITY

Physical Therapy Program ASU Station 10923 San Angelo, Texas 76909-0923 (325) 942-2545 (325) 942-2548 FAX

Student Health Form

Name of Student			
Address			
Telephone ()			
Blood Pressure	Blood type		
IMMUNIZATIONS	Date Initial Series Completed	Booster Date	
Poliomyelitis	-		
Mumps			
Measles			
Rubella			
Pertussis			
Tetanus			
Diphtheria			
Chicken Pox*			
Chest X-Ray or P.P.D test			
Flu			
Hepatitis B Series**			
*Students must show evidence of imm **Students declining this series must	sign Declination Form on reverse s	ide.	
I have examined	Student name	and	
find him/her to be in good phys free from the above listed disea	sical health. I also find that the	e above-named student is	
Restrictions or Limitations:			
Date	Physician Signa	Physician Signature	
Physician License # Address:	Physician Name	Physician Name (printed)	
Phone: ()			



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Hepatitis B Vaccine Declination

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at my own expense. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. I also understand that I may be refused placement at clinical sites that require proof of Hepatitis B vaccination. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can initiate the vaccination series.