



ANGELO STATE UNIVERSITY
 College of Nursing and Allied Health
 Department of Physical Therapy
 ASU Station, #10923
 San Angelo, Texas 76909-0001
 (325) 942-2545
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Student Health Form

Name of Student _____

Address _____

Telephone (____) _____ Birthdate _____

Blood Pressure _____ Blood type _____

IMMUNIZATIONS	Date Initial Series Completed	Booster Date
Poliomyelitis		
Mumps		
Measles		
Rubella		
Tetanus		
Diphtheria		
Chicken Pox*		
Chest X-Ray or Mantoux/P.P.D test		
Hepatitis B Series**		

*Students must show evidence of immunity by history, immunization or titer.

**Students declining this series must sign and attach Declination Form.

I have examined _____ and
Student name

find him/her to be in good physical health for full-time clinical internships (8 weeks). I also find that the above-named student is free from the above listed diseases.

Restrictions or Limitations:

 Date

 Physician Signature

 Physician License #

 Physician Name (printed)

 Address:

 Phone: (____) _____