STUDENT NAME: _____ Date of Birth: _____
MONTH, DAY, YEAR

Supplemental Page B – Medical Examination Form

Return Form with Application or by fax (510) 465-3257 or email to international@peralta.edu

Medical Examination Form

This section is to be **completed and signed by a Physician and affixed with a hospital stamp.** You may submit a copy of your immunization records, translated in English, instead of this form. Each record must include Month and Year.

Description	Yes	No	Action	Date (mm/yy)
1. Tetanus-Diphtheria	☐	☐	a) Completed primary series of tetanus-diphtheria immunizations	
	☐	☐	b) Received tetanus-diphtheria booster within the last 10 years	
2. M.M.R (Measles, Mumps Rubella)	☐	☐	a) Dose 1-Immunized at 12 months or after and before 5 years	
	☐	☐	b) Dose 2- Immunized at 5 years or later	
3. Measles (Rubella) if given instead of M.M.R.	☐	☐	a) Had disease; confirmed by office record	
	☐	☐	b) Born before 1957 and therefore considered immune	
	☐	☐	c) Had report of immune titer. Specify date of titer	
	☐	☐	d) Immunized with vaccine at 12 months after birth or later	
4. Rubella, if given instead of M.M.R.	☐	☐	a) Had report of immune titer. Specify date of titer	
	☐	☐	b) Immunized at 12 months after birth or later	
5. Mumps, if given instead of M.M.R.	☐	☐	a) Had disease, confirmed by office	
	☐	☐	b) Immunized with vaccine at 12 months after birth or later	

6. Tuberculosis: *Check appropriate boxes. Give date and test results.*

a) PPD (Mantoux) test within the past year: ☐ Yes ☐ No **Test Result:** ☐ Positive ☐ Negative **Date:** _____
(Note: Tine or Monovac not acceptable)

b) Positive PPD-Chest X-ray required: ☐ Yes ☐ No **Test Result:** ☐ Positive ☐ Negative **Date:** _____

c) Had BCG Vaccine ☐ Yes ☐ No **Test Result:** ☐ Positive ☐ Negative **Date:** _____
(Note: Chest X-Ray required if PPD not done)

—Physician Information & Signature—

Name: _____ **Phone:** _____

Address: _____ **City/Country:** _____

Medical No.: _____ **Email:** _____

Signature: _____ **Date:** _____