

## Occupational Therapy Department Student Health Record

Name (Last, First, Initial): \_\_\_\_\_

Student ID: \_\_\_\_\_

Semester Admitted to Program: \_\_\_\_\_

Liability Insurance: Provided by CSU – Lloyd’s of London

CPR Training— you must complete training and be CPR certified for Healthcare Providers (American Heart Association or American Red Cross): Attach Copy of CPR Card

Expiration Date: \_\_\_\_\_

HIPAA Module: \_\_\_\_\_  
Training Date Signature

Infection Control Module: \_\_\_\_\_  
Training Date Signature

Mandated Reporter Module: \_\_\_\_\_  
Training Date Signature

**TO BE CHECKED, DATED & SIGNED BY HEALTH SERVICE OR PRIVATE PHYSICIAN OR ATTACH COPIES OF PAPERWORK FROM M.D. Requires signature and office stamp (For Example: Please attach documentation verifying health requirements are met)**

	Date	MD Signature or attach appropriate form	Date	MD Signature or attach appropriate form
PHYSICAL EXAM				
TB SKIN TEST				
HEPATITIS B (complete series)				
MEASLES, MUMPS, RUBELLA (MMR) OR DISEASE DATE (Required by Uni. For Admission)				
CHICKEN POX				
TETANUS				