

**American Consulate General**  
Johannesburg, South Africa

**INSTRUCTIONS REGARDING MEDICAL EXAMINATIONS FOR VISA APPLICANTS**

Every visa applicant, regardless of age, is required to undergo a complete medical examination prior to the issuance of the immigrant visa. The Medical examination will include a medical history, physical examination, chest X-ray and blood tests for syphilis and HIV (Human Immunodeficiency Virus). The completed medical forms, together with the serological and blood test results, will be given to the applicant in a SEALED envelope. The sealed envelope must be presented to the Consulate General on the day of your visa interview. However, please do NOT bring your x-ray plates with you as they are not necessary for the interview.

**Kindly read carefully and follow the instructions below:**

1. Contact one of the designated panel physicians to arrange a medical exam. Please give the doctor the date of the immigrant visa appointment or explain that the exam is for an immigrant visa. The panel physician will advise you of the cost of the exam and tests. For further details about the medical examination, visit: [www.travel.state.gov](http://www.travel.state.gov) (go to Interview Preparation, then Medical Examination).
2. Bring **two passport-sized photos** and **your passport** with you when appearing for the examination since, as indicated above, verification of your identity must be presented and the number of your passport photographed on to the X-Ray plate.
3. Kindly arrange to collect the completed Medical Reports and the X-Ray plate yourself. It will not be forwarded to you. The fee for the examination (approximately R850.00 for the medical examination, excluding vaccinations) must be borne by the applicant. Please note that the fees quoted are approximate and applicable only to South Africa.
4. **Although you should bring copies of prior medical records, immunization records**, do NOT obtain any vaccinations prior to your medical examinations. You will pay an additional fee for each vaccine that you require. If you have any questions about required vaccines please contact one of the three listed panel physicians for advice on U.S. government requirements.
5. A TB skin test is required for all children aged 2-14 years (inclusive).
6. X-Rays and Serological tests are **not** required in cases of children under the age of fifteen years, **unless** the medical examiner has reason to suspect that such tests are necessary or if a child has as positive TB test.
7. If specifically requested by a pregnant immigrant visa applicant, a panel physician may waive the chest X-Ray examination requirement.

***(FOR YOUR INFORMATION: A Medical Examination Report is valid for a period of 12 months prior to the issuance of the visa unless you have what is termed a Class A condition)***





U. S. Department of State  
**MEDICAL EXAMINATION FOR  
 IMMIGRANT OR REFUGEE APPLICANT**

OMB No. 1405-0113  
 EXPIRATION DATE: 03/31/2011  
 ESTIMATED BURDEN: 10 minutes  
 (See Page 2 - Back of Form)

<b>Photo</b>	<b>Name</b> (Last, First, MI.) _____		<b>Sex:</b> <input type="checkbox"/> M <input type="checkbox"/> F	
	<b>Birth Date</b> (mm-dd-yyyy) _____			
	<b>Birthplace</b> (City/Country) _____ / _____			
	<b>Present Country of Residence</b> _____		<b>Prior Country</b> _____	
	<b>U.S. Consul</b> (City/Country) _____ / _____			
	<b>Passport Number</b> _____		<b>Alien (Case) Number</b> _____	
	<b>Date</b> (mm-dd-yyyy) of Medical Exam _____		<b>Date</b> (mm-dd-yyyy) of Prior Exam, if any _____	
<b>Date Exam Expires</b> (6 months from examination date, if Class A or TB condition exists, otherwise 12 months) (mm-dd-yyyy) _____				
<b>Exam Place</b> (City/Country) _____ / _____			<b>Panel Physician</b> _____	
<b>Radiology Services</b> _____			<b>Screening Site</b> (name) _____	
<b>Lab</b> (name for HIV/syphilis/TB) _____ / _____ / _____				

**(1) Classification (check all boxes that apply):**

**No apparent defect, disease, or disability** (see Worksheets DS-3024, DS-3025 and DS-3026)

**Class A Conditions (From Past Medical History and Physical Examination Worksheets)**

<input type="checkbox"/> TB, active, infectious (Class A, from Chest X-Ray Worksheet)	<input type="checkbox"/> Human immunodeficiency virus (HIV)
<input type="checkbox"/> Syphilis, untreated	<input type="checkbox"/> Hansen's disease, lepromatous or multibacillary
<input type="checkbox"/> Chancroid, untreated	<input type="checkbox"/> Addiction or abuse of specific* substance without harmful behavior
<input type="checkbox"/> Gonorrhea, untreated	<input type="checkbox"/> Any physical or mental disorder (including other substance-related disorder) with harmful behavior or history of such behavior likely to recur
<input type="checkbox"/> Granuloma inguinale, untreated	
<input type="checkbox"/> Lymphogranuloma venereum, untreated	

\*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

**Class B Conditions (From Past Medical History and Physical Examination Worksheets)**

<input type="checkbox"/> TB, active, noninfectious (Class B1, from Chest X-Ray Worksheet) Treatment: <input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Completed	<input type="checkbox"/> Hansen's disease, prior treatment
<input type="checkbox"/> TB, inactive (Class B2, from Chest X-Ray Worksheet) Treatment: <input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Completed See Section 4 on page 2 for TB treatment details	<input type="checkbox"/> Hansen's disease, tuberculoid, borderline, or paucibacillary
<input type="checkbox"/> Syphilis (with residual deficit), treated within the last year	<input type="checkbox"/> Sustained, full remission of addiction or abuse of specific* substances
<input type="checkbox"/> Other sexually transmitted infections, treated within last year	<input type="checkbox"/> Any physical or mental disorder (excluding addiction or abuse of specific* substance but including other substance-related disorder) without harmful behavior or history of such behavior unlikely to recur
<input type="checkbox"/> Current pregnancy, number of weeks pregnant _____	*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics
<input type="checkbox"/> Other (specify or give details on checked conditions from worksheets) _____	

**(2) Laboratory Findings (check all boxes that apply):**

**Syphilis:**  **Not done**

	Test name	Date(s) run (mm-dd-yyyy)	Negative	Positive	Titer 1	Notes
Screening			<input type="checkbox"/>	<input type="checkbox"/>		
Confirmatory			<input type="checkbox"/>	<input type="checkbox"/>		

Treated:  Yes  No

If treated, therapy:  Benzathine penicillin, 2.4 MU IM  Other (therapy, dose):E \_\_\_\_\_

Date(s) treatment given (3 doses for penicillin) \_\_\_\_\_

**HIV:**  **Not done**

	Test name	Date(s) run (mm-dd-yyyy)	Negative	Positive	Indeterminate	Notes
Screening			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Secondary			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Confirmatory			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**(3) Immunizations (See Vaccination Form, check all boxes that apply) Not required for refugee applicants.**

- Vaccine history complete  Vaccine history incomplete, requesting waiver (*indicate type below*)  
 Incomplete vaccine history, no waiver requested  Blanket waiver  Individual waiver

I certify that I understand the purpose of the medical examination and I authorize the required tests to be completed.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Panel Physician Signature

\_\_\_\_\_  
Date (mm-dd-yyyy)

**(4) Tuberculosis Treatment Regimen**

(Fill out if applicant has taken in the past, or is now taking TB medication. If drug doses or dates not known or not available, mark "unknown".)

- Check if therapy currently prescribed (*if current, don't mark "End Date"*)

<u>Medication</u>	<u>Dose/Interval</u> <i>(i.e., mg/day)</i>	<u>Start Date</u> <i>(mm-dd-yyyy)</i>	<u>End Date</u> <i>(mm-dd-yyyy)</i>
<input type="checkbox"/> Isoniazid (INH)	_____	_____	_____
<input type="checkbox"/> Rifampin	_____	_____	_____
<input type="checkbox"/> Pyrazinamide	_____	_____	_____
<input type="checkbox"/> Ethambutol	_____	_____	_____
<input type="checkbox"/> Streptomycin	_____	_____	_____
<input type="checkbox"/> Other, specify	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Applicant's weight (kg) \_\_\_\_\_

Remarks \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES**

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time required for searching existing data sources, gathering the necessary data, providing the information required, and reviewing the final collection. Persons are not required to provide this information in the absence of a valid OMB approval number. Send comments on the accuracy of this estimate of the burden and recommendations for reducing it to: U.S. Department of State (A/RPS/DIR) Washington, DC 20520.

We ask for information on this form, in the case of applicants for immigrant visas, to determine medical eligibility under INA Sections 212(a) and 221(d), and, in the case of refugees, as required under INA Section 412(b)(4) and (5). If an immigrant visa is issued or refugee status granted, you will convey this form to U.S. Department of Homeland Security (DHS) for disclosure to the Centers for Disease Control and Prevention and to the U.S. Public Health Service. Failure to provide this information may delay or prevent the processing of your case. If an immigrant visa is not issued or refugee status is not granted, this form will be treated as confidential under INA Section 222(f).

U.S. Department of State  
**MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET**

OMB No. 1405-0113  
 EXPIRATION DATE: 03/31/2011  
 ESTIMATED BURDEN: 35 minutes  
 (See Page 2 - Back of Form)

For use with DS-2053

Name (Last, First, MI)		Exam Date (mm-dd-yyyy)
Birth Date (mm-dd-yyyy)	Passport Number	Alien (Case) Number

**1. Past Medical History** (indicate conditions requiring medication or other treatment after resettlement and give details in Remarks)

NOTE: The following history has been reported, has not been verified by a physician, and should not be deemed medically definitive.

<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"><b>No</b></td> <td style="width:10%;"><b>Yes</b></td> <td><b>General</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Illness or injury requiring hospitalization (including psychiatric)</td> </tr> <tr> <td colspan="3"><b>Cardiology</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Angina pectoris</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hypertension (high blood pressure)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cardiac arrhythmia</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Congenital heart disease</td> </tr> <tr> <td colspan="3"><b>Pulmonology</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>History of tobacco use</td> </tr> <tr> <td></td> 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**2. Physical Examination** (indicate findings and give details in Remarks)

No  Yes Applicant appears to be providing unreliable or false information, specify \_\_\_\_\_

Height \_\_\_\_\_ cm    Weight \_\_\_\_\_ kg    Visual Acuity at 20 feet: Uncorrected L 20/ \_\_\_\_\_ R 20/ \_\_\_\_\_  
 BP \_\_\_\_\_ / \_\_\_\_\_ (mmHg)    Heart rate \_\_\_\_\_ /min    Respiratory rate \_\_\_\_\_ /min    Corrected L 20/ \_\_\_\_\_ R 20/ \_\_\_\_\_

\*N, normal; A, abnormal; ND, not done

<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"><b>N*</b></td> <td style="width:10%;"><b>A*</b></td> <td style="width:10%;"><b>ND*</b></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>General appearance and nutritional status</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hearing and ears</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Eyes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Nose, mouth, and throat (include dental)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Heart (S1, S2, murmur, rub)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Breast</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Lungs</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Abdomen (including liver, spleen)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Genitalia (including circumcision, infection(s))</td> </tr> </table>	<b>N*</b>	<b>A*</b>	<b>ND*</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General appearance and nutritional status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing and ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose, mouth, and throat (include dental)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart (S1, S2, murmur, rub)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen (including liver, spleen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia (including circumcision, infection(s))	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"><b>N*</b></td> <td style="width:10%;"><b>A*</b></td> <td style="width:10%;"><b>ND*</b></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Inguinal region (including adenopathy)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Extremities (including pulses, edema)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Musculoskeletal system (including gait)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Skin (including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Lymph nodes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Nervous system (including nerve enlargement)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Mental status (including mood, intelligence, perception, thought processes, and behavior during examination)</td> </tr> </table>	<b>N*</b>	<b>A*</b>	<b>ND*</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inguinal region (including adenopathy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities (including pulses, edema)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal system (including gait)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin (including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous system (including nerve enlargement)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental status (including mood, intelligence, perception, thought processes, and behavior during examination)
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**3. Additional Testing Needed Prior to Approving Medical Clearance**

No Yes

Physical examination or laboratory results contradict medical history

Referral prior to departure If yes, provide results \_\_\_\_\_  
\_\_\_\_\_

Referral prior to departure If yes, provide results \_\_\_\_\_  
\_\_\_\_\_

**4. Follow-up Needed After Arrival**

No       Yes, within 1 week       Yes, within 1 month       Yes, within 6 months

For continuing medication, list type, dose, and frequency \_\_\_\_\_  
\_\_\_\_\_

For continuing other treatment, specify \_\_\_\_\_  
\_\_\_\_\_

**5. Remarks (describe any abnormal history, abnormal findings, and resulting interventions)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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**PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES**

Public reporting burden for this collection of information is estimated to average 35 minutes per response, including time required for searching existing data sources, gathering the necessary data, providing the information required, and reviewing the final collection. Persons are not required to provide this information in the absence of a valid OMB approval number. Send comments on the accuracy of this estimate of the burden and recommendations for reducing it to: the U.S. Department of State (A/ISS/DIR) Washington, DC 20520.

**AUTHORITIES** The information is sought pursuant to Sections 212(a), 221(d), 101, and 412(b)(4) and (5) of the Immigration and Nationality Act.

**PURPOSE** The primary purpose for soliciting medical information is to determine whether an applicant is eligible to obtain a visa and alien registration. This form is designed to record the result of the medical examination required by INA 221(d), which determines whether an applicant has a medical condition that renders the applicant ineligible under INA Section 212(a).

**ROUTINE USES** The information solicited on this form may be made available to the U.S. Department of Homeland Security for disclosure to the Centers for Disease Control and Prevention and to the U.S. Public Health Service. The information provided also may be released to federal agencies for law enforcement, counter-terrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies for certain personnel and records management matters. Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.



# CHEST X-RAY AND CLASSIFICATION WORKSHEET

For Use with DS-2053

Complete Sections 1 through 5, As Applicable

OMB No. 1405-0113  
EXPIRATION DATE: 03-31-2011  
ESTIMATED BURDEN: 10 MINUTES  
(See Page 2 - Back of Form)

Name (Last, First, MI.)	Age
-------------------------	-----

Birth Date (mm-dd-yyyy)	Passport Number	Alien (Case) Number
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**1. Chest X-Ray** (Mark All that Apply)

History of Tuberculosis (TB) Disease       TB Signs or Symptoms

Contact with Person with TB       Adult (With or Without Any of the Other)

*(If child does not have any of the above, stop here.)*

**2. Chest X-Ray Findings**      Date Chest X-Ray Taken (mm-dd-yyyy) \_\_\_\_\_

Normal Findings

Abnormal Findings (Indicate findings and interpretation, by checking all that apply, and any other in the table below.)

<input type="checkbox"/> Can Suggest ACTIVE TB (Need Smears)	<input type="checkbox"/> Can Suggest INACTIVE TB (Need Smears if Symptomatic)	<input type="checkbox"/> OTHER X-Ray Findings
<input type="checkbox"/> Infiltrate or Consolidation <input type="checkbox"/> Any Cavitory Lesion <input type="checkbox"/> Nodule with Poorly Defined Margins <i>(Such as Tuberculoma)</i> <input type="checkbox"/> Pleural Effusion <input type="checkbox"/> Hilar/Mediastinal Adenopathy <input type="checkbox"/> Linear, Interstitial Markings <input type="checkbox"/> Other (Such as Miliary Findings)	<input type="checkbox"/> Discrete Fibrotic Scar or Linear Opacity <input type="checkbox"/> Discrete Nodule(s) without Calcification <input type="checkbox"/> Discrete Fibrotic Scar with Volume Loss or Retraction <input type="checkbox"/> Discrete Nodule(s) with Volume Loss or Retraction <input type="checkbox"/> Other (Such as Bronchiectasis)	<input type="checkbox"/> Follow-Up Needed <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Cardiac <input type="checkbox"/> Pulmonary <input type="checkbox"/> Other <input type="checkbox"/> No Follow-Up Needed for Pleural thickening, diaphragmatic tenting, blunting costophrenic angle, solitary calcified nodule or granuloma or minor musculoskeletal or cardiac finding

Remarks \_\_\_\_\_

**3. Sputum Smears**

No, Applicant has No Signs or Symptoms of TB and :  X-Ray Suggests INACTIVE TB, this is a **Class B2/TB**

OTHER X-Ray Findings Suggest Follow-Up Needed after Arrival, this is **B Other**

OTHER X-Ray Findings Suggest No Follow-Up Needed, this is **No Class**

X-Ray Normal, this is **No Class**

Yes, Applicant has (Mark All that Apply) :

<input type="checkbox"/> Signs or Symptoms of TB Present, See Section 1	Positive	Negative	Dates Obtained (mm-dd-yyyy)
<input type="checkbox"/> X-Ray Suggests ACTIVE TB, See Section 2	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Sputum Smear Results and X-Ray**  
At least One Smear Result POSITIVE and

Any Chest X-Ray Finding, this is **Class**  
*(Normal or Abnormal findings)*

**Three Smear Results NEGATIVE and**

X-Ray Normal with

Signs of Symptoms Resolved, this is **No Class**

Signs or Symptoms Suggest Follow-Up Needed after Arrival, this is **B Other**

X-Ray Suggests ACTIVE or INACTIVE TB, this is **Class B1/TB**

OTHER X-Ray Findings Suggest Follow-Up Needed After Arrival, this is **Class B**

4.  No Class     Class A/TB     Class B1/TB     Class B2/TB     Class B Other, Follow-Up

5. Follow-Up Needed After  No  Yes      If Yes, for  Not TB Condition  TB Condition

Remarks (If yes, specify condition below and on DS-2053; include additional tests, and therapy used with start and stop dates and any changes.)





# VACCINATION DOCUMENTATION WORKSHEET

U.S. Department of State

For Use with DS-2053

To Be Completed by Panel Physician Only

Name (Last, First, MI.)

Exam Date (mm-dd-yyyy)

Birth Date (mm-dd-yyyy)

Passport Number

Alien (Case) Number

REQUIRED FOR U.S. IMMIGRANT VISA APPLICANTS

NOT REQUIRED FOR REFUGEE APPLICANTS

NOTE FOR PANEL PHYSICIANS:  
For refugee applicants, please complete only if reliable vaccination documents are available.

OMB No. 1405-0113  
EXPIRATION DATE: 03/31/2011  
ESTIMATED BURDEN: 30 minutes  
(See Page 2 of 2)

## 1. Immunization Record

Vaccine	Vaccine History Transferred From a Written Record (List Chronologically from Left to Right)				Vaccine Given by Panel Physician (mm-dd-yyyy)	Completed Series (✓ if Completed, Write "VH" if Varicella History, or write Date of Lab Test if Immune)	Blanket Waiver(s) To Be Requested if Vaccination Not Medically Appropriate, Check Suitable Box(es) Below			Not Fall (Flu) Season
	Date Received (mm-dd-yyyy)	Date Received (mm-dd-yyyy)	Date Received (mm-dd-yyyy)	Date Received (mm-dd-yyyy)			Not Age Appropriate	Insufficient Interval	Contra- indicated	
Specify (check) vaccine: <input type="checkbox"/> DT <input type="checkbox"/> DTP <input type="checkbox"/> DTaP										
Specify (check) vaccine: <input type="checkbox"/> Td <input type="checkbox"/> Tdap										
Specify (check) vaccine: <input type="checkbox"/> Polio -OPV <input type="checkbox"/> IPV										
Specify (check) vaccine: <input type="checkbox"/> MMR (Measles-Mumps- Rubella) <input type="checkbox"/> Rubella										
Specify (check) vaccine: <input type="checkbox"/> Measles <input type="checkbox"/> Measles - Rubella										
Specify (check) vaccine: <input type="checkbox"/> Mumps <input type="checkbox"/> Mumps - Rubella										
Rotavirus										
Hib										
Hepatitis A										
Hepatitis B										
Meningococcal										
Human papillomavirus										
Varicella										
Zoster										
Pneumococcal										
Influenza										

## 2. Results

- Vaccine History Incomplete
- Applicant may be eligible for blanket waiver(s) because vaccination(s) not medically appropriate (as indicated above).
- Applicant will request an individual waiver based on religious or moral convictions.
- Vaccine history complete for each vaccine, all requirements met (Documented Above).
- Applicant does not meet vaccination requirements for one or more vaccines and no waiver is requested.

## 3. Panel Physician (Name)

Panel Physician (Signature)

Date (mm-dd-yyyy)



## PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

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