



English Language Program (ELP) MEDICAL REQUIREMENTS

PLEASE TAKE THIS FORM TO YOUR DOCTOR IN YOUR HOME COUNTRY

Student's Name _____
Last Name First Name Middle Name

Date of Birth _____ Age _____ ELP # 974 - -
Month Day Year FOR USE BY ELP OFFICE ONLY

Gender (circle one): Female Male

IMMUNIZATIONS :

To Be Completed by Medical Doctor in Your Country:

- Rubella** Date Immunization Given _____
Or
Date of Immunity Test _____ Result _____
- Measles (Rubeola)** Date Immunization Given _____
Or
Date of Immunity Test _____ Result _____

FREEDOM FROM TUBERCULOSIS :

I certify that the above-named patient is free from active tuberculosis as determined by:
Check One:

- Negative chest x-ray taken within the past year. Date taken: _____
- Negative tuberculosis skin test given within the past year. Date given: _____

Signature of Medical Doctor _____

Print Name _____ Title _____ Date _____

Address _____

Bring signed form with you on Registration Day.

