**IMMUNIZATION RECORD AND PHYSICAL EXAM**

Please return to: Saint Vincent College Wellness Center, 300 Fraser Purchase Rd., Latrobe PA 15650

Phone: 724-805-2115 FAX: 724-805-2121 - **Due by JULY 15th**

*This information is strictly for use by Health Services and will not be released without student consent*

|  |  |  |  |
| --- | --- | --- | --- |
| Students’ Name  First, mid, last |  | Date of Birth | Cell Phone |

Blood Pressure\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_Pulse\_\_\_\_\_\_\_\_\_\_\_\_\_Height\_\_\_\_\_\_\_\_\_\_\_\_Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Corrected Vision: Right 20/\_\_\_\_\_\_\_\_\_\_\_\_ Left 20/\_\_\_\_\_\_\_\_\_\_\_\_\_ Contacts Glasses

|  |
| --- |
| IMMUNIZATION RECORD **(OR ATTACH COPY OF THE STUDENTS IMMUNIZATION RECORD)** |
| 1. **Measles, Mumps, Rubella (MMR).** **Two immunizations** **REQUIRED.** 1st MMR month/day/ year received\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2nd MMR month/day/year received\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. **Meningitis Vaccine (MCV4)** **REQUIRED** by Pennsylvania Law for all on-campus residents   Received \_\_\_\_\_\_\_\_\_\_\_\_\_ Received\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Meningitis B received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. TB: PPD Date received:\_\_\_\_\_\_\_\_\_\_\_\_\_ Date read\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Results(mm)\_\_\_\_\_\_\_\_\_\_\_\_\_   Date received:\_\_\_\_\_\_\_\_\_ Date read\_\_\_\_\_\_\_\_\_\_\_\_ Date received:\_\_\_\_\_\_\_\_\_ Date read\_\_\_\_\_\_\_\_\_\_\_\_  Required for foreign born persons, persons with compromised immune system, and close contact with infectious TB cases. If positive, was chest X-ray taken? Yes No Result\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Tetanus/Diphtheria/Pertussis(booster every 10 years for adults) date received\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Hepatitis A (include dates) 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. Hepatitis B (include dates) 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. Polio (include last date of booster) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. Varicella Vaccine (include dates) 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I waive the right to vaccinate for: Religious Medical Other reasons Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any irregularities of the following systems? If yes please describe.

|  |  |  |
| --- | --- | --- |
|  | Normal | Abnormal |
| Head, ears, nose or throat |  |  |
| Eyes |  |  |
| Respiratory |  |  |
| Cardiovascular |  |  |
| Gastrointestinal |  |  |
| Genitourinary |  |  |
| Musculoskeletal |  |  |
| Endocrine |  |  |
| Neuropsychiatric |  |  |
| Skin |  |  |
| Teeth |  |  |
| **Allergic to Medication, Food, Other**: | | |

Recommendations for physical activity: Unlimited or Limited:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the patient now under treatment for any medical or emotional condition? Yes No

Do you have any recommendations regarding the care of this student? Yes No

Physician Signature (M.D., D.O., PAC, CRNP)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_

Address/phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_