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: 724-532-5044

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	

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 /Menactra REQUIRED** by Pennsylvania Law for all on-campus residents Received _____ Received_____
3. 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_____
4. Tetanus/Diphtheria/Pertussis(booster every 10 years for adults) date received_____
5. Hepatitis A (include dates) 1._____2._____
6. Hepatitis B (include dates) 1._____2._____3._____
7. Polio (include last date of booster) _____
8. 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 :		

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:_____