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

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 (MCV4) REQUIRED** by Pennsylvania Law for all on-campus residents Received _____________ Received________________ Meningitis B 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:____