

# IMMUNIZATION RECORD

Provider: Please complete and **sign both sides** of this form.

**Wheaton**

**Complete and return this form by June 30, 2008**  
Office of Health & Wellness, Wheaton College, Norton, MA 02766  
Fax: 508-286-5409

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

Immunization information is not considered confidential.

## REQUIRED

### 1. DPT (DIPHTHERIA, PERTUSSIS, TETANUS)

Tetanus-diphtheria booster **within last 10 years:** Month/Year \_\_\_\_\_

### 2. MMR (MEASLES, MUMPS, RUBELLA)

1<sup>st</sup> Dose – Immunized **on/after first birthday:** Month/Year \_\_\_\_\_

2<sup>nd</sup> Dose – Immunized **at least one month later:** Month/Year \_\_\_\_\_

*OR if given separately*

#### A. MEASLES (RUBEOLA)

1<sup>st</sup> Dose – Immunized with live vaccine **on/after first birthday:** Month/Year \_\_\_\_\_

2<sup>nd</sup> Dose – Immunized with live vaccine **at 5 years or later:** Month/Year \_\_\_\_\_

Actual immune titer value: \_\_\_\_\_ Month/Year \_\_\_\_\_

#### B. RUBELLA

1<sup>st</sup> Dose - Immunized **on/after first birthday:** Month/Year \_\_\_\_\_

Actual immune titer value: \_\_\_\_\_ Month/Year \_\_\_\_\_

#### C. MUMPS

1<sup>st</sup> Dose - Immunized **on/after first birthday:** Month/Year \_\_\_\_\_

Actual immune titer value: \_\_\_\_\_ Month/Year \_\_\_\_\_

### 3. HEPATITIS B

Immunized with vaccine: 1<sup>st</sup> Dose \_\_\_\_\_ 2<sup>nd</sup> Dose \_\_\_\_\_ 3<sup>rd</sup> Dose \_\_\_\_\_

Actual immune titer value: \_\_\_\_\_ Month/Year \_\_\_\_\_

### 4. BACTERIAL MENINGITIS

Immunized **within last 5 years & 2 weeks prior to Orientation** Month/Year \_\_\_\_\_

Not immunized; blue waiver form completed and signed.

### 5. TUBERCULOSIS

Negative PPD test: Month /Year \_\_\_\_\_

Positive PPD test: Month/Year \_\_\_\_\_

Chest X-ray Results \_\_\_\_\_

Medication \_\_\_\_\_

## RECOMMENDED

### 6. VARICELLA (CHICKENPOX)

History of disease: Month/Year \_\_\_\_\_

Immunized with vaccine: 1<sup>st</sup> Dose \_\_\_\_\_ 2<sup>nd</sup> Dose \_\_\_\_\_

Actual immune titer value: \_\_\_\_\_ Month/Year \_\_\_\_\_

Signature of Health Care Provider: \_\_\_\_\_

**PHYSICAL EXAM FORM**

Provider: Please complete and **sign both sides** of this form.

Fax: 508-286-5409

**The physical examination must have been completed since July 1, 2007**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Exam Date: \_\_\_\_\_

System	Normal	Abnormal	Comments	Results
1. Neurological				BP
2. HEENT				P
3. Cardiac				Ht.
4. Respiratory				Wt.
5. Gastro-intestinal				BMI
6. Genito-urinary				Optional Hearing
7. Endocrine				Optional Vision
8. Skin				Optional HCT
9. Musculo-skeletal				Optional CHOL
10. Psychological				Optional UA

This Student is in:  excellent health  good health  poor health

This Student:  **may** participate in sports without restrictions

**may not** participate in sports

may participate in sports with the following restrictions \_\_\_\_\_

Allergies: \_\_\_\_\_

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

Significant medical, surgical or mental health history: \_\_\_\_\_

**Signature of Health Care Provider:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_