



Part I: Personal Information

Please note: This section is to be completed by the student

Last Name _____ First Name _____ Date of Birth ____/____/____
Home Address _____
Street City State Zip
Mobile Phone # (____) _____ Home Phone (____) _____ Email _____

Part II: Required Immunizations

Please note: This section is to be completed and signed by your Health Care Provider.

A. Measles, Mumps, Rubella: Required for students born in 1957 or later. 1st dose must have been given after 1st birthday.

	Dose 1	Dose 2	Laboratory/serologic evidence of immunity
M.M.R. (Measles, Mumps, Rubella)	____/____/____	____/____/____	____/____/____
OR			
Measles	____/____/____	____/____/____	____/____/____
Mumps	____/____/____	____/____/____	____/____/____
Rubella	____/____/____	____/____/____	____/____/____

Exception: I was born before 1957, and therefore I am exempt from this requirement.

B. Meningococcal Polysaccharide Vaccine: Required of all students living on campus
Meningococcal Vaccine _____

C. Tetanus-Diphtheria (Td booster dose in the last ten years or Primary Series with DTap, DTP, or TD)
One Td Booster dos within the last ten years prior to matriculation _____

OR
Completion of primary series (DTap, DTP, or TD) within the last ten _____
years prior to matriculation

D. Varicella (Either a history of chicken pox, two doses of vaccine given at least 28 days apart, or a positive Varicella antibody.)

History of Disease	Yes	No	If yes, what year: _____
Laboratory/serologic evidence of immunity	N/A		If applicable, list date: _____
First Dose – Given at 12 month of age or later (1 st dose has to have been given after 1995)			____/____/____
Second Dose – Given at least 28 days after first does			____/____/____

E. Hepatitis B Series – 18 years and/or younger. Three doses of vaccine or a positive surface antibody.

	Dose 1	Dose 2	Dose 3
	____/____/____	____/____/____	____/____/____
OR			
Laboratory/serologic evidence of immunity or prior infection	____/____/____		

F. TB Test and/or Chest X-ray: Required of all students. It must have been given within the last 12 months.

TB Test Given	____/____/____	Results: _____mm
Chest X-Ray	____/____/____	Results: _____

G. Exemptions

- This student is exempt from all the above immunization on grounds of permanent medical contraindication.
- This student is temporarily exempt from the above immunization until ____/____/____.
- I declare that I will be enrolling in ONLY courses offered by distance learning.

Health Care Provider

Printed Name _____ Signature _____ Date ____/____/____
Address _____ Phone (____) _____



Part II: Physical Examination

To the Examining Physician:

Please review the student's medical history and note on an attached sheet any discrepancies of which you are aware in the information provided. The information supplied will be used as background information for providing health care. It is strictly for the use of Paine College's Division of Student Affairs and Enrollment Management and will not be released with the student's or his/her parents'/guardian's consent.

Date of Exam: ____/____/____

Student's Name: _____

Height: _____ Weight: _____ B/P Reading: _____

PPD/Tuberculin Skin Test Date: ____/____/____ Results: _____ Date: ____/____/____

Are there any abnormalities of the following: (please describe if "Yes")

	Yes	No	Description
Head, Ear, Nose & Throat	_____	_____	_____
Eyes	_____	_____	_____
Teeth, Gums	_____	_____	_____
Face, Neck	_____	_____	_____
Lymph Nodes	_____	_____	_____
Breasts	_____	_____	_____
Heart	_____	_____	_____
Abdomen	_____	_____	_____
Inguinal rings	_____	_____	_____
Genitalia	_____	_____	_____
Anus, Rectum	_____	_____	_____
Back	_____	_____	_____
Arms, Hands	_____	_____	_____
Legs, Feet	_____	_____	_____
Skin	_____	_____	_____

Is there loss of or seriously impaired function of:

Any organ? ____ Yes ____ No If "Yes", explain _____
Any limb? ____ Yes ____ No If "Yes", explain _____

Is limitation for physical activity suggested (e.g. Physical Ed. Athletics, etc.)? ____ Yes ____ No

Is student under treatment/care for any medical or emotional condition? ____ Yes ____ No

Comments: _____

(Please type or print physician's name, address, and telephone number below):

Physician Signature

Date