Division of Student Affairs and Enrollment Management

Lion ID#________________________

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 (1st 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 (_____)___________

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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