PAINE COLLEGE

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.)

	Yes	No	If yes, what year:
History of Disease			_____/___/_____
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