DeSales University

IMMUNIZATION RECORD AND PHYSICAL EXAMINATION

(Please type or print.)

Last Name First Name Middle Name

IMMUNIZATION HISTORY – PLEASE PROVIDE DATES: (See accompanying letter for requirements.)

Tetanus-Diphtheria* Date primary series completed _____ (DTP or DTaP)
(within 10 years) Most recent booster _____
Please circle: Td or Tdap

Polio* Date primary series completed _____

Tuberculosis Medical Evaluation and Screening Form completed*

Date Completed _____

Hepatitis B: 1st _____ 2nd _____ 3rd _____
(Highly recommended) Required for health care majors

***These immunizations are REQUIRED.**

M.M.R.* (Measles, Mumps, Rubella -Two doses required.**)**

Dose 1 Dose 2

Varicella vaccine: 1st _____ 2nd _____ or HX of disease _____

Meningitis Immunization*:

Menactra _____ (Date)

or Menomune _____ (Date)

**Please complete the Meningitis Immunization/Waiver Form in addition to providing the immunization date above.*

Other

Physician Signature: Date:

Date of Examination: Height Weight Blood Pressure Pulse

Vision: R uncorrected corrected L uncorrected corrected

Urinalysis: Specific Gravity Sugar Protein Other

	Normal	Abnormal – Describe
Skin		
Head and scalp		
Eyes		
Ears/Hearing		
Mouth, nose, throat		
Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Musculoskeletal		
Neurologic		
Emotional		

Please identify any problem that will limit activity or need ongoing care by the Health Center Staff. Give your recommendations for this care.

Physician's Name *(Please Print)*: Signature:

Address: Date:

Phone Number:

Fax Number:

Return to: DeSales University Health Center
McShea Student Center
2755 Station Avenue
Center Valley, PA 18034