Wheaton

IMMUNIZATION RECORD & PHYSICAL EXAM

MAIL TO: Cynthia Maricle, Wheaton College, 26 East Main Street, Norton, MA 02766 or FAX TO: 508-286-5409 by July 1, 2015.

NAME: _____ DATE OF BIRTH: _____ AGE: _____

PHYSICIAN: COMPLETE THE FOLLOWING *REQUIRED* PHYSICAL EXAM & *REQUIRED* IMMUNIZATION INFORMATION and SIGN BELOW. Physical exam must take place after 8/1/2014.

VARSITY ATHLETES: *The NCAA requires a* ***physical exam dated within 6 months prior to the first day of practice****. If you have questions, contact Greg Steele, Head Athletic Trainer, at 508-286-3986. Submit one copy of your physical exam to Student Health Services* ***AND*** *one copy to Greg Steele, Head Athletic Trainer, Wheaton College, 26 East Main Street, Norton, MA 02766.*

SYSTEM	NORMAL	FINDINIGS
Neurological		
HEENT		
Cardiac		• Heart Murmur: _____ • Femoral Pulses: _____ • Appearance of Marfan Syndrome: YES NO
Musculo-skeletal		
Respiratory		
GI/GU		
Endocrine/Skin		
Psychological		

DATE OF EXAM _____

BP _____ P _____

HT. _____ WT. _____ BMI _____

Significant PMH (please provide additional documentation if indicated): _____

_____

_____

Medications: _____

_____

Allergies: _____

☐ **May participate in athletics with the following restrictions:** _____

☐ **May participate in athletics**

☐ **May *not* participate in athletics**

PHYSICIAN: IMMUNIZATION REQUIREMENTS VARY STATE TO STATE. IF THE FOLLOWING VACCINES HAVE NOT BEEN RECEIVED, PLEASE ADMINISTER AS APPROPRIATE. Immunization information is not confidential.

1. Tdap Booster (within the last 10 yrs. regardless of interval since last tetanus containing vaccine) _____/ _____/ _____ (Month/Date/Year)

2. MMR #1 _____/_____/_____ #2 _____/_____/_____ (Month/Date/Year)
OR Actual positive antibody titer value:
Measles: _____ Month/Date/Year _____/_____/_____
Rubella: _____ Month/Date/Year _____/_____/_____
Mumps: _____ Month/Date/Year _____/_____/_____

3. Hepatitis B #1 _____/_____/_____ #2 _____/_____/_____ (2 dose series ☐) #3 _____/_____/_____
OR Actual positive antibody titer value:
HBsAb (Hepatitis B surface antibody) _____ Month/Date/Year _____/_____/_____

4. Bacterial Meningitis
Menomune (MPSV4) (received within the last 5 years – if not, revaccination required) _____/_____/_____ (Month/Date/Year)
OR
Menactra or Menveo (MCVA4) _____/_____/_____ (Month/Date/Year)
OR
Immunization declined; enclosed blue waiver form signed ☐

5. Varicella #1 _____/ _____/ _____ #2 _____/ _____/ _____ (Month/Date/Year)
OR Positive history of disease ☐ Month/Date/Year _____/ _____/ _____
OR Actual positive antibody titer value: _____Month/Date/Year _____/ _____/ _____

PROVIDER SIGNATURE _____

PHONE _____ FAX _____

ADDRESS _____