

**IMMUNIZATION RECORD**

Provider: Complete and **sign both sides** of this form.  
Return completed forms by December 15, 2009  
Office of Health & Wellness, Wheaton College, Norton, MA 02766  
Fax: 508-286-5409

**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Immunization information is not considered confidential.

**REQUIRED IMMUNIZATIONS**

**1. DPT (DIPHTHERIA, PERTUSSIS, TETANUS)**

Tetanus-diphtheria booster **within last 10 years:** Month/Year \_\_\_\_\_

**2. MMR (MEASLES, MUMPS, RUBELLA)**

1<sup>st</sup> Dose – Immunized **on/after first birthday:** Month/Year \_\_\_\_\_

2<sup>nd</sup> Dose – Immunized **at least one month later:** Month/Year \_\_\_\_\_

*OR if given separately*

**A. MEASLES (RUBEOLA)**

1<sup>st</sup> Dose – Immunized with live vaccine **on/after first birthday:** Month/Year \_\_\_\_\_

2<sup>nd</sup> Dose – Immunized with live vaccine **at 5 years or later:** Month/Year \_\_\_\_\_

Actual immune titer value: \_\_\_\_\_ Month/Year \_\_\_\_\_

**B. RUBELLA**

Immunized with vaccine **on or after first birthday:** Month/Year \_\_\_\_\_

Actual immune titer value: \_\_\_\_\_ Month/Year \_\_\_\_\_

**C. MUMPS**

Immunized with vaccine **on or after first birthday:** Month/Year \_\_\_\_\_

Actual immune titer value: \_\_\_\_\_ Month/Year \_\_\_\_\_

**3. HEPATITIS B**

Immunized with vaccine: 1<sup>st</sup> dose \_\_\_\_\_ 2<sup>nd</sup> dose \_\_\_\_\_ 3<sup>rd</sup> dose \_\_\_\_\_

Actual immune titer value: \_\_\_\_\_ Month/Year \_\_\_\_\_

**4. BACTERIAL MENINGITIS – received within last 5 years and 2 weeks prior to Orientation Day**

Immunized with vaccine: Month/Year \_\_\_\_\_

Not immunized; blue waiver form completed and signed:

**5. VARICELLA (CHICKENPOX)**

Immunized with vaccine: 1<sup>st</sup> dose \_\_\_\_\_ 2<sup>nd</sup> dose \_\_\_\_\_

Actual immune titer value: \_\_\_\_\_ Month/Year \_\_\_\_\_

History of disease: Month/Year \_\_\_\_\_

**Signature of Health Care Provider:**

# PHYSICAL EXAM

Provider: Complete and **sign both sides** of this form.

**The physical examination must have been completed since September, 2008.  
All athletes must receive a physical within 6 months prior to practice start date.**

Return completed forms by December 15, 2009

Fax: 508-286-5409

NAME \_\_\_\_\_ DOB \_\_\_\_\_ EXAM DATE \_\_\_\_\_

BP \_\_\_\_\_ P \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_

The Student:  may participate in sports without restrictions

may **not** participate in sports

may participate in sports with the following restrictions \_\_\_\_\_

Reason for limiting activity or sports: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Significant medical, surgical or psychiatric conditions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SYSTEM	NORMAL	SIGNIFICANT FINDINGS
Neurological		
HEENT		
Cardiac		
Respiratory		
GI/GU		
Endocrine/Skin		
Psychological		

**Signature of Health Care Provider:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Notes: