



Student Name: \_\_\_\_\_

**PART I: IMMUNIZATION RECORD -- NECESSARY FOR REGISTRATION --- NO EXCEPTIONS**

To be completed by you and your health care provider. Please record and attach all immunization records

**REQUIRED IMMUNIZATIONS**

**A. Tetanus-Diphtheria (TD)**

- 1. Tetanus-Diphtheria booster, within the last ten years ..... / .....  
Or Mo Yr
- 2. Tdap booster (preferred) to replace a single dose of Td at least 2-5 years since last dose of Td ..... / .....  
Mo Yr

**B. M.M.R. (Measles, Mumps, Rubella) (Two doses required or proof of immunity by titre enclosed)** 1. \_\_\_\_\_ / \_\_\_\_\_ 2. \_\_\_\_\_ / \_\_\_\_\_  
Mo. Yr. Mo. Yr.

**C. Varicella** (History of chicken pox, positive varicella antibody, or two doses of vaccine meets the requirement)

- 1. History of Disease Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_
- 2. Varicella antibody Date \_\_\_\_\_ Result: Reactive \_\_\_\_\_ Non-reactive \_\_\_\_\_
- 3. Immunization Dose #1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Mo Day Yr  
Dose #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ given at least 12 weeks after first dose ages 1-23 or at least 4 weeks after first dose if age 13 years or older.  
Mo Day Yr

**D. Hepatitis B** ..... Dose #1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose #3 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Mo. Day Yr. Mo. Day Yr. Mo. Day Yr.

**D. Tuberculosis (Required for all international and high risk students. Please consult your health care provider )**

- 1. PPD (Mantoux) within the past 6 months Result: \_\_\_\_\_ mm induration (horizontal diameter). . \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Mo Day Yr.
- 2. If greater than 10 mm induration, copy of chest x-ray report required. Date x-ray done \_\_\_\_\_ Results \_\_\_\_\_
- 3. Did patient receive INH therapy for positive TB test? Yes \_\_\_\_\_ No \_\_\_\_\_ Date treatment began: \_\_\_\_\_ Date treatment completed \_\_\_\_\_

**OTHER IMMUNIZATIONS (STRONGLY RECOMMENDED) Please record and attach all immunization records**

**A. HPV (human papillomavirus)** (females only) Dose #1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose # 2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose # 3 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Mo Day Yr Mo Day Yr Mo Day Yr

**B. Hepatitis A** Dose #1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Mo. Day Yr. Mo. Day Yr.

**C. Meningococcal Vaccine** \_\_\_\_\_ / \_\_\_\_\_  
Mo. Yr.

**PART II: MEDICAL EVALUATION BY A HEALTH CARE PROVIDER IS REQUIRED WITHIN THE LAST YEAR**

Male \_\_\_\_\_ Female \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_ Urinalysis: Alb \_\_\_\_\_ Sugar \_\_\_\_\_ Blood \_\_\_\_\_

Nml Abn GENERAL Assessment and Comments

- Head \_\_\_\_\_
- Eyes \_\_\_\_\_
- ENT \_\_\_\_\_
- Mouth/teeth \_\_\_\_\_
- Lungs/heart \_\_\_\_\_
- Abdomen \_\_\_\_\_
- GU \_\_\_\_\_
- Skin \_\_\_\_\_
- Neurological \_\_\_\_\_
- Feet \_\_\_\_\_

Nml Abn MUSCULOSKELETAL Assessment and Comments

- C-spine \_\_\_\_\_
- Shoulders \_\_\_\_\_
- Elbows \_\_\_\_\_
- Wrists \_\_\_\_\_
- Hands \_\_\_\_\_
- Spine \_\_\_\_\_
- Hips \_\_\_\_\_
- Knees \_\_\_\_\_
- Ankles \_\_\_\_\_

**ASSESSMENT:** \_\_\_\_\_

**PLAN:** \_\_\_\_\_

I HEREBY CERTIFY that this medical report is complete, true, and correct. I certify further, that in my opinion and based on this medical examination, the applicant is \_\_\_\_\_ medically fit, is not \_\_\_\_\_ medically fit to follow a normal College program.

**For Athletic Participation**

- A. To my knowledge, this individual is fit to compete in a College athletic program. Yes  No
- B. List any restrictions to athletic participation: \_\_\_\_\_
- C. Any special equipment or protective devices required \_\_\_\_\_
- D. EKG recommended if any significant cardiac history or risk.

**Date:** \_\_\_\_\_ **Clinician's Signature:** \_\_\_\_\_ **OFFICE STAMP REQUIRED:**

**RETURN FORM TO:** Saint Mary's College of California  
Student Health and Wellness Center  
P.O. Box 3006, Moraga, CA 94575-3006  
Phone (925) 631-4254 Fax (925) 376-2238