Colby·Sawyer College

Student Name:_____ **Date of Birth:**____/____/_____
Please Print LAST, FIRST Name MM/DD/YEAR

PHYSICAL EXAMINATION / IMMUNIZATIONS Entrance Requirements

Exam must be completed by Health Care Provider within **2 years** of Colby-Sawyer College entrance. Varsity athletes must have exam within **6 months** of first team practice.

TO THE STUDENT: PLEASE BE PREPARED TO DISCUSS COLBY-SAWYER COLLEGE'S IMMUNIZATION REQUIREMENTS WITH YOUR HEALTH CARE PROVIDER. FAILURE TO COMPLY WILL RESULT IN DELAY IN THE COLLEGE CHECK-IN PROCESS.

TO THE EXAMINER: This is the only form that will be accepted for college entrance.
Please review the student's history and complete this form.
Confidentiality: This information is subject to Baird Health & Counseling Center Notice of Privacy Practices.

I. PHYSICAL EXAMINATION DATE OF EXAM: MM_____/DD_____/YEAR_____

BLOOD PRESSURE /	RESTING PULSE	WEIGHT	HEIGHT

ANY ABNORMALITIES OF:					
DENTAL / MOUTH	YES	NO	EXTREMITIES	YES	NO
EYES / FUNDUS	YES	NO	MENTAL HEALTH STATUS	YES	NO
EAR / NOSE / THYROID	YES	NO	MUSCULOSKELETAL SYS.	YES	NO
SKIN / SCALP	YES	NO	NEUROLOGICAL SYSTEM	YES	NO
ABCOMEN	YES	NO	LUNGS	YES	NO
HEART	YES	NO	THORAX	YES	NO

If **YES**, please explain
Please note chronic illness / injuries / disabilities. Attach supporting information if applicable.

CURRENT MEDICATIONS:

RECOMMENDATION: (participation status required)

❑ **Full Unlimited Athletic Participation** ❑ **Limited Participation** ❑ **Clearance withheld**
Explanation (if clearance withheld or participation limited):

Provider's Signature:_____ Print Name:_____

Address:_____

Tel: _____ Fax:_____ Date: MM_____/DD_____/YEAR_____

BAIRD HEALTH & COUNSELING CENTER, COLBY-SAWYER COLLEGE
541 MAIN ST, NEW LONDON, NH 03257 tel. 603.526.3621 / fax 603.526.3453 BHCC@colby-sawyer.edu [revMar2018]

Colby·Sawyer College

Student Name:_____ **Date of Birth:**____/____/_____

Please Print LAST, FIRST Name MM/DD/YEAR

II. PROOF OF IMMUNIZATIONS REQUIRED: circle yes or no

MMR Required: Has student been given 2 doses, minimum of 28 days apart with the first dose given on or after 1st birthday?	Yes	*No*
Hepatitis B Required: Has series been completed or does student demonstrate serologic immunity?	Yes	*No*
Tetanus/Diphtheria/Pertussis Required: Has Tdap been given within the last 10 years? Please provide date: _____/_____/_____	Yes	*No*
Quadrivalent Meningococcal Required: Has vaccine been administered? At what age? _____ If vaccine given before age 16, booster is required. Booster given? Must cover types A, C, Y, W135 ***Strongly recommended:** Meningococcal vaccine (Bexsero or Trumenba) to protect against serogroup B disease Reference: https://www.cdc.gov/vaccines/vpd/mening/public/index.html#types	Yes Yes	*No* *No*
Varicella verification Required: Has student been given 2 doses a minimum of 28 days apart? **If No**, check all that apply: ❑history varicella disease ❑herpes zoster dx ❑serologic evidence of immunity	Yes	*No*

If immunization requirements are declined, a notarized request for exemption is required.
Go to http://www.colby-sawyer.edu then, Student Life; Baird Health & Counseling; Forms; Request Vaccine Exemption

Tuberculosis:
Baird Health and Counseling Center practices an approach to tuberculosis screening and treatment that is consistent with the TB Elimination Strategy promoted by the US Public Health Service Advisory Council on the Elimination of Tuberculosis.

Has student ever had positive TB skin test (TST)?	*Yes*	No
Has student had close contact with anyone who is sick with TB?	*Yes*	No
Does the student have occupational, medical or lifestyle risk factors for TB?	*Yes*	No
Was student born in a country with a rate of tuberculosis greater than or equal to 20 cases per 100,000 population[1] and has or will student have arrived in the US within the past five years upon coming to CSC?	*Yes*	No
Has student ever traveled to or been in a country with a rate of tuberculosis greater than or equal to 20 cases per 100,000 population[1]?	*Yes*	No

[1]This includes most countries in Africa, Asia, Eastern Europe, Russia, Central/South America and the Caribbean. For more information: http://apps.who.int/gho/data/ Note: Students who come from countries with high rates of TB disease may be required to repeat Tuberculosis testing 10-12 weeks after arrival at CSC.

If the answers to TB questions above are all NO -> no further action required

If the answer is YES to any question above, a further assessment of TB risk is required within six months of college entry.

❑ Attach dates and results of any testing done and any other relevant documentation (eg., TST, Interferon Gamma Release Assay, Chest Xray). TST results to be reported in millimeters.

❑ An assessment of TB risk has been done and the student found to be low risk.

III. OTHER IMMUNIZATIONS: _____

Provider's Signature:_____ Print Name:_____

Address:_____

Tel: _____ Fax:_____ Date: MM_____/DD_____/YEAR_____

Please return this form to:

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