Physical Examination Form and Certificate of Immunization

Student's Name ___________________________ *D.O.B.* ________

Physical Examination—To be completed by a health care provider (MD, NP, or PA).
This examination must have been done within the last 12 months and must be complete before attending classes.

Height _____ Weight _____ Pulse ______ Blood Pressure ________

ALLERGIES: include medicines, foods, bites and stings etc. **None**: __ (check)

Allergy *	Reactions	Medication Required

Carries an Epi pen? **Yes** **No**

MAJOR DISEASE OR ILLNESS / MAJOR INJUIRES: past **and** present

Disease/Injury *	Hospitalization?	Date(s)	Current effects

MEDICATIONS: prescription **and** over the counter **None**: __ (check)

Medication *	Condition	Dosage (amount & freq)	Current side effects

If medication taken "as needed", indicate date of last dosage: _____________

*Please use another paper to share more information, if necessary.

Is there a history of substance abuse? **Yes No** If yes, please explain*:

Is there a history of psychological counseling? **Yes No** If yes, please explain*:

RESTRICTIONS / RECOMMENDATIONS*: include diet, medicines, or activities

I have examined the person herein described, have reviewed the medical history, and it is my opinion that this person is physically and emotionally able to engage in all activities, except as noted above.

Examining Provider Signature: ____Date: ____________

Please Print Examining Provider Name: ______________________________________

Address: ____________________________________
Phone: ____________________________________

OVER

Immunization Requirements for Vermont College Students

Updated 2/24/21

Student's Name ______________________________ *D.O.B.* __________

- Vaccines are not required for college students born before 1956
- **Tdap/Td booster must be within last 10 years**
- For MMR, a minimum of 4 weeks between doses; 1st dose must be given after 1st birthday
- For Varicella a minimum of 4 weeks between doses if age 13 or older (12 weeks for under age 13)

Required Vaccines	**Date(s) Given**
1) Tdap or Td (Tetanus-Diptheria-Pertussis)	______________
2) MMR (Measles, Mumps, Rubella)	1) ____________ 2) ____________

OR Positive Titer Dates

__/__/__	__/__/__	__/__/__
Measles	Mumps	Rubella

3) Meningococcal (Only required for first year students 21 years or younger, living in dorms)	__________
4) HBV (Hepatitis B)	1) ________ 2) ________ 3) ________
OR Positive Titer Date	__/__/__
5) Varicella (Chickenpox)	1) ________ 2) ________
OR History of disease Sign "**Documentation of Varicella***" next page	
OR Positive Titer Dates	__/__/__

To the best of my knowledge, the person named above has received the required immunizations.

Do not sign unless minimum immunization requirements are met.

Signed (MD, NP, or PA) ________________________________

Print Name ______________________________ Date ______________

Student's Name ____________________________ D.O.B. _________________

***Documentation of Varicella** (Chickenpox Disease)

I (name)______________________ verify that the above listed student had varicella (chickenpox) disease on (date):________

____ Date: ___________________
Signature of Parent/Guardian of student OR Student 18 and over

Statement of Exemption to Immunization Law

For _______________ for the following vaccine(s): ______________
Student's name, printed

__ Medical Exemption: The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions. MD, NP or PA must sign.

__ Religious Exemption: The above named person him/herself is an adherent to a religious belief opposed to immunizations.

Signed _______________________________________ Date: _______________
MD, NP, or PA (for Medical Exemption) / Parent/Guardian or Student over 18 years (For Religious)

Printed Name _______________________________________