MITCHELL COLLEGE

Health Services Student Health Form
Physical Exam and Immunization Record

Student Name:	Date of Birth:

TO BE COMPLETED BY HEALTHCARE PROVIDER

EXAM MUST BE COMPLETED 1-2 YEARS PRIOR TO ENROLLMENT (Non-Athlete)
****Varsity Athletes: February 15th or later (Fall Sports), March 15th or later (Winter/Spring Sports)****

Date of Exam:

Height:	Weight:	BMI:	Blood Pressure:	Pulse:	Vision: 20/_____ ☐ Corrected

Clinical Evaluation	Normal	Abnormal	Comments
General			
Integumentary			
HEENT			
Respiratory *If student requires an inhaler for asthma symptoms, please provide asthma action plan if clinically indicated.			☐ Asthma Action Plan
Cardiovascular			
Gastrointestinal			
Renal/Urinary			
Gynecological (*Women Only*)			
Musculoskeletal			
Metabolic/Endocrine			
Neurological *If history of seizures, please provide seizure action plan			☐ Seizure Action Plan
Hematologic/Lymphatic			
Emotional/Psychological			
Other Findings			

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REQUIRED VACCINATIONS OR PROOF OF IMMUNITY (ATTACH ALL TITER RESULTS)

Measles-Mumps-Rubella Vaccine

2 doses required or proof of positive titer or history of disease confirmed by MD

Date of Dose #1: _____

Date of Dose #2: _____

Date of Disease: _____

MD Signature: _____

☐ Titers Attached

Varicella Vaccine

2 doses required or proof of positive titer or history of disease confirmed by MD

Date of Dose #1: _____

Date of Dose #2: _____

Date of Disease: _____

MD Signature: _____

☐ Titers Attached

Meningitis Vaccine

(Serogroup A, C, Y, W135)

Must be administered **after age 16 and within the past 5 years prior to enrollment.**
Only required if living on campus

☐ Resident ☐ Commuter

Date of Vaccine: _____
Select Type:
☐ Menactra ☐ Menveo
☐ Other _____

BELOW ARE RECOMMENDED FOR ALL STUDENTS; *REQUIRED FOR NURSING STUDENTS*

Hepatitis B Vaccine

Series of 3 doses or proof of positive titer or statement of refusal

Date of Dose #1: _____

Date of Dose #2: _____

Date of Disease: _____

☐ Titers Attached
☐ Statement of Refusal Attached

COVID-19 Vaccine

*Primary vaccine series + boosters as recommended by CDC **MAY** be required by some clinical sites.*

Primary Vaccine Series:
Date of Dose #1: _____

Date of Dose #2: _____

☐Pfizer ☐Moderna ☐J&J

Booster:
Date of Dose #1: _____
Date of Dose #2: _____

☐Pfizer ☐Moderna ☐J&J

Adult Tetanus, Diphtheria, Pertussis Vaccine

1 dose every 10 years (sooner if injured)

☐Td ☐Tdap

Date of Dose: _____

Seasonal Influenza Vaccine

Administered yearly

Date of Dose: _____

Tuberculosis Screening (Only *required* for Nursing students)

Skin Test (PPD) or Quantiferon Gold Lab Test

☐ PPD
☐ Quantiferon Gold

Date of Test: _____ Result: _____mm

PLEASE ATTACH LAB RESULTS

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All information will remain confidential in accordance with HIPAA laws.

Is this student able to meet the physical and emotional demands of college life?

☐ YES ☐ NO If NO, please attach letter explaining reason and recommendations.

Do you have any recommendations for physical activity (PE, intramurals) and participation in Varsity sports?

☐ UNLIMITED ☐ LIMITED If LIMITED, please explain or attach letter if needed _____

Do you have any recommendations regarding the care of this student?

☐ YES ☐ NO If yes, please explain or attach letter if needed _____

Is the patient currently under treatment for any medical or emotional condition?

☐ YES ☐ NO If yes, what conditions?

_____

_____

_____

_____

ADDITIONAL REQUIREMENTS FOR NCAA ATHLETES:

NCAA Bylaw 17.1.5.1: all student-athletes must provide documentation of **Sickle Cell Trait Testing, from either a newborn panel or a sickle cell solubility test (SST).**

NCAA Bylaw 17.1.6.4: all physicals must be **signed by a Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO).** Physicals completed by any other healthcare provider must be signed by the supervising physician.

☐ I have examined the above-named student. I confirm that the information above is accurate to the best of my knowledge.

Signature of Healthcare Provider *(Parent or guardian CANNOT sign as the provider)*	**Date**	**Phone**
		Fax
Print Name of Healthcare Provider	**Address (include city and state)**	

Forms may be submitted via fax, email, or postal service to Admissions.
Admissions@mitchell.edu Fax: 860-701-5090
Keep a copy of these forms until you are certain they have been received.

Connecticut state law and the policy of Mitchell College mandate that a completed health certificate be on file.

Failure to submit all required information will result in a hold on your student account.