ROSEMONT COLLEGE

CONFIDENTIAL

PHYSICIAN'S MEDICAL REPORT 2017-2018

Name: _____ Date of Birth _____ Class of ____

Gender: M _____ F ____ (Circle appropriate category/ies) Classification: FR SO JR SR TR

Street: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Student's Cell Phone _____

Parent and/or relative to be contacted in case of emergency:

Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

In order for us to provide health care to a Rosemont student, the following information is required:

I. Immunization

MMR #1: Date: _____
(Measles, Mumps, Rubella)

MMR #2: Date: _____

Tetanus and Diphtheria
(Td) Booster: Date: _____
Within Past 10 years or
Tdap

Meningococcal Vaccine
Date: _____

HPV Vaccine (Optional)
Date: #1 ____
#2 _____
#3 _____

Polio Series Completed:
☐ Yes ☐ No Date: _____ Last Booster

Hepatitis B: #1 Date: _____ #2 Date: _____ #3 Date: _____
(immunization series)

Varicella vaccine: Date: _____ Other: _____ Date: _____

History of chicken pox? _____

II. Tuberculosis Test (at risk students)

Mantoux PPD (within past 12 months) Date: _____ Results: Positive _____ mm
Negative _____mm

Chest X-ray (if positive tuberculosis test) Date: _____ Results: Positive _____
Negative _____

III. Physical Exam

A. Height: _____ C. Blood Pressure: _____

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B. Weight: _____ D. Pulse Rate: _____

IV. Personal History

A. Please list and give dates of any major illnesses, injuries, disabilities or emotional disorders suffered in the past.

B. Is this student currently under treatment for any illnesses, injuries or emotional issues? If so, please indicate the nature of the treatment, and any medication or recommendations that the Wellness Center staff should be aware of.

C. Resident students only: If this student requests resident status, are there any special accommodations that are required in order for this student to live in the residence hall? **A separate request for ADA accommodations must be submitted, in writing, from your physician to the Dean of Students.**

D. Significant family health history:

E. Please list all allergies or abnormal reactions to drugs, food, bee stings, etc.:

F. After a thorough medical evaluation, list any significant findings:

G. This student can _____ cannot _____ participate in Intercollegiate Athletics and Intramural sports.

Physician's stamp here:

_____
(Physician's Signature)

_____
(Address)

_____

_____
(Telephone Number)

_____
(Date)

<u>Submission of this form is mandatory</u>

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