Incoming Student Health Requirements

Please complete ALL required steps below by July 31st. Student health records will not be verified as compliant if any information is missing.

1) From Your Primary Care Provider:

- ☐ Documentation of Physical performed on or after July 1st, 2022, signed by medical provider
- ☐ Documentation of required immunizations signed by medical provider
  - ☐ Hepatitis B
    - ☐ 3 doses
  - ☐ Varicella
    - ☐ 2 doses
  - ☐ MMR (Measles, Mumps, Rubella)
    - ☐ 2 doses
  - ☐ TDaP (Tetanus, Diphtheria, Pertussis)
    - ☐ 1 dose within the last 10 years
  - ☐ Quadrivalent Meningitis (ACWY)
    - ☐ 2 doses if 1st dose given before age 16

If seeking medical or religious immunization exemption, please contact our office directly

2) Upload to Medicat Patient Portal

- ☐ Copy of signed physical
- ☐ Copy of signed immunization record
- ☐ Copy of insurance card (front & back)

3) Input on Medicat Under Immunizations Tab

- ☐ Required immunization dates

4) Electronic Forms on Medicat

- ☐ Complete Bryant University Health Services Informed Consent
- ☐ Complete Emergency Contacts
- ☐ Complete Registration and Health History Form
- ☐ Complete Tuberculosis (TB) Screening Form

Bryant UNIVERSITY

Student's Name: _____ Date of Birth:_____
Date of Exam: _____ (MUST be within one year of university entry - - six months for athletes)

To be completed by Health Care provider (ALL sections must be completed):

Medications: _____ **Allergies:** _____
Current Medical Diagnoses: _____

Blood Pressure: _____ **Pulse:** _____ **Height (inches):** _____ **Weight (lbs):** _____ **BMI:** _____

NORMAL	Check each item in appropriate column Enter NE if not evaluated	Abnormal: Please describe any abnormal findings
	General Appearance	
	Head/neck/thyroid	
	Eyes	
	Ears	
	Mouth and Throat	
	Nose and Sinuses	
	Chest/Breast	
	Heart	
	Lungs	
	Abdomen	
	Skin	
	Musculoskeletal/Extremities	
	Neurologic	
	Genitalia	
	Additional Exam	

List any specialist(s) this patient is followed by (endocrine, dermatology, gastroenterology, cardiology, pulmonology, oncology, etc.):
_____

Does this patient require clearance from any of the above specialties prior to college entrance? Yes ___ No ___

By signing below, I certify as the health care provider completing this form, that the above listed patient is medically cleared to participate in all collegiate activities, which may include residential living, physical activity, and academics.

Print Name: _____ Phone: _____
Signature: _____ Date: _____

IMMUNIZATION RECORD

To be completed and signed by health care provider

STUDENT'S NAME: _____ **DOB:** _____

Required Immunizations

All information must be in English (dates must include month, day, and year)

TETANUS, DIPTHERIA, PERTUSSIS (MUST be within 10 years)

TDAP ____/____/____

MMR (MEASLES, MUMPS, RUBELLA) - 2 doses required

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____

HEPATITIS B - 3 doses required

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____

VARICELLA (Chickenpox) - 2 doses required

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____

MENNINGOCOCCAL QUADRIVALENT (Meningitis) - 2 doses, if dose 1 given before age 16

Dose #1 ____/____/____ Dose #2 ____/____/____

Recommended Immunizations

COVID-19 (Please upload a copy of your Covid-19 vaccination card

Dose #1 _____/_____/_____ Pfizer_____ Moderna_____ J&J_____ Other _____
Dose #2 _____/_____/_____ Pfizer_____ Moderna_____ J&J_____ Other _____
Dose #3 _____/_____/_____ Pfizer_____ Moderna_____ Other _____

HEALTH CARE PROVIDER:

Print Name: _____ Phone: _____

Signature: _____ Date: _____