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) - 1 dose at age 16 or older

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

HEALTH CARE PROVIDER:

Print Name: _____ Phone: _____

Signature: _____ Date: _____