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
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: ___________

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<thead>
<tr>
<th>NORMAL</th>
<th>Check each item in appropriate column Enter NE if not evaluated</th>
<th>Abnormal: Please describe any abnormal findings</th>
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<tbody>
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<td>General Appearance</td>
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<td>Head/neck/thyroid</td>
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<td>Ears</td>
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<td>Mouth and Throat</td>
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<td>Nose and Sinuses</td>
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<td>Genitalia</td>
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<td>Additional Exam</td>
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</table>

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, DIPHTHERIA, 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)
Pfizer_____    Moderna_____    J&J_____    Other ________
Dose #1 _____/_____/_____    Dose #2 _____/_____/_____    Dose #3 _____/_____/_____  
Pfizer_____    Moderna_____    J&J_____    Other ________

HEALTH CARE PROVIDER:
Print Name: ___________________________________    Phone: ____________
Signature: ___________________________________________    Date: ____________