WAGNER COLLEGE

Name:_____ Birth date:____/_____/____
Last First Middle Month Day Year

ID:_____ Gender_____ Preferred Pronouns_____

IMMUNIZATION RECORD

To Be **Completed by Student**, reviewed and **signed by Health Provider** to minimize processing delays.
Immunization records are NOT confidential as required by law.

Complete and return both forms together via fax 718-420-4170 or scan and email to
studenthealthservice@wagner.edu

REGISTRATION FOR SUBSEQUENT SEMESTERS WILL BE WITHHELD UNTIL THIS INFORMATION IS COMPLETE AND RETURNED TO WAGNER COLLEGE CENTER FOR HEALTH AND WELLNESS			
REQUIRED Measles, Mumps and Rubella: New York State Law and Wagner College requires that all students born after 1956 provide documentation of 2 doses of vaccine or laboratory proof of immunity to Measles, Mumps, and Rubella as a condition of attendance at the institution.			
Or ⬇ ➡	FIRST dose given after 1968 and on or after 12 months of age; SECOND dose separated at least 28 days from first dose. MMR #1_____/_____/_____ MMR #2_____/_____/_____ *Month Day Year Month Day Year*	**OR**	Lab Tests (see below) ⬇
Measles (Rubeola), Mumps and RubellaVirus IgG, Antibody test for each demonstrating immunity (Titer). Copy of laboratory report including range must be attached.			

REQUIRED Hepatitis B: All students enrolled in 12 or more credits per semester are required to have THREE doses of HepB vaccine.

Date dose #1_____/_____/_____ Date dose #2_____/_____/_____ Date dose #3_____/_____/_____
Month Day Year Month Day Year Month Day Year

REQUIRED Meningococcal Meningitis: New York State Law requires that all students RESIDING IN HOUSING receive Meningococcal A, C, Y, and W-135 Vaccine. Student will NOT be permitted entry to campus housing unless Health Services has received proof of vaccination.

Accepted ONLY if administered less than 5 years ago.

A, C, Y, W-135 vaccine #1 Date:_____/_____/_____
Month Day Year

REQUIRED Tetanus, Diptheria, Pertussis: Most recent injection and please mark correct vaccine given.

Date dose #1_____/_____/_____ Date dose #2_____/_____/_____
Month Day Year Month Day Year

VOLUNTARY IMMUNIZATION HISTORY
Human Papilloma Virus (HPV) 3 injection series Recommended for all students before age 27

Date dose #1_____/_____/_____ Date dose #2_____/_____/_____ Date dose #3_____/_____/_____
Month Day Year Month Day Year Month Day Year

Hepatitis A (2 injection series)

Date dose #1_____/_____/_____ Date dose #2_____/_____/_____
Month Day Year Month Day Year

HEALTH CARE PROVIDER NAME, ADDRESS AND SIGNATURE REQUIRED BY NY STATE LAW				
Name		Telephone		Stamp:
Address		Email		
		Fax		
Signature		Date		

WAGNER COLLEGE

Name:_____Birth date:_____/_____/____
Last First Middle Month Day Year

ID:_____Gender_____Preferred Pronouns_____

Required by all students. Please print clearly as this form will be scanned into the patient record.

PHYSICAL EXAMINATION
(To Be Completed by Health Care Provider)

STUDENT: Please attach completed Immunization Record for provider confirmation.
EXAMINER: Complete this form and confirm the immunization record.
This person has been accepted at Wagner College. The information will not affect his/her status and will be used only as background for providing health care. With the exception of the immunization record, no part of this medical record will be disclosed or released without written client permission.

MEDICAL EXAMINATION (Required within the past year and prior to the first day of class.)
Blood pressure:_____Pulse:_____Height:_____Weight:_____
VISION: Uncorrected: (Left)_____(Right)_____Corrected: (Left)_____(Right)_____

PHYSICAL EXAMINATION

	NORMAL	ABNORMAL FINDINGS
Skin		
HEENT		
Neck		
Cardiovascular		
Lungs		
Breasts		
Abdominal		
Genito-urinary		
Musculo-skeletal		
Neurological		
Psychological		
Skin		

Does the applicant have a history of emotional, psychological or psychiatric disorder?
Please list any allergies including reaction:
Please list any current medications and associated problem:
Examiner's Comments/Recommendations:

Is student able to participate in rigorous physical activity? ____ Yes ____ No

HEALTH CARE PROVIDER NAME, ADDRESS AND SIGNATURE REQUIRED BY NJ STATE LAW				
Name		Telephone		Stamp:
Address		Email		
		Fax		
Signature		Date		

Instructions to student: Complete and return both forms together via fax 718-420-4170 or scan and email to studenthealthservice@wagner.edu