

***Please do not return pages separately**

For office use only _____	Date: _____
Last name: _____	
First name: _____	
Student ID: _____	

Carroll College Student Immunization Record -CONFIDENTIAL- Required for Attendance

A Student Immunization form is **REQUIRED** for **ALL** new students, including those who are returning after an absence of one calendar year or transfer students.
Your registration will not be finalized until a completed Student Immunization Record is received. Please use ink, and print or type.

Name: *Last:* _____ *First:* _____ *Middle name:* _____

Date of Birth _____ Gender: _____ Social Security Number: _____ Application Type: _____

Permanent address: _____ City _____ State _____ Zip _____

Home Telephone number: _____ Parent's Names: _____

Local Telephone or cell number: _____

Carroll College requires that every student have the immunizations listed below.

Required Immunizations

Deadline – prior to attending orientation.

MMR (Measles, Mumps, Rubella)

Montana requires proof of two MMR's
If born after Jan. 1957*

MMR #1	MMR #2
mm/dd/yy	mm/dd/yy

DPT (Diphtheria, Tetanus, Pertussis)

a minimum of three shots; **plus Tetanus booster**
within the past ten years

DPT # 1	DPT # 2	DPT # 3	DPT #4	Tetanus
mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy

Polio Series

Series of 3 doses of live oral polio
one after fourth birthday, or two injects

Polio # 1	Polio #2	Polio #3	Polio #4
mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy

Meningitis Vaccine

One vaccination required

Meningitis
mm/dd/yy

* If born before Jan. 1957, proof of having had the disease or a titre to prove immunity is required.

Required within one year prior to attendance: Tuberculosis (Tb, or PPD) Skin Test: Date given _____ Date Read _____ Result: _____

Recommended Immunizations

The following immunizations are not required, but you are strongly encouraged to have these immunizations. The shots are available through the Wellness Center through-out the school year.

Hepatitis B Vaccine, series of three

mm/dd/yy	mm/dd/yy	mm/dd/yy
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Flu Vaccine

mm/dd/yy

Pneumococcal Vaccine

mm/dd/yy

Chicken Pox

Date of vaccination / titre,
or date of disease

mm/dd/yy

To the best of my knowledge, this person has received the above immunizations
Signed: _____ Title: _____ Date: _____

-OR- **Attach a copy** of immunizations from your high school,
previous college, or from your family physician.

Name: _____ Student ID number: _____

Family History (Please circle ALL that are in your family history.)

Alcoholism	Clinical Depression	Heart Disease	High blood pressure	Seizures
Blood Disease	Diabetes	Hepatitis B	Migraine	Tuberculosis
Cancer	Emotional problems	Hereditary disorder	Schizophrenia	Ulcers, bowel problems

Personal History (Please circle any medical problems you currently have, or have ever had.)

Asthma	Hemorrhoids	concussion/head injury	excessive weight gain / loss	abnormal Pap smear	breast lumps
Bronchitis	hernia	dizziness	loss of consciousness	blood / protein in urine	cancer
Chronic cough	ulcer	frequent colds / ear infections	meningitis / encephalitis	discharge from penis / vagina	congenital disorders
Hay fever	anemia	frequent sinus infections	paralysis	frequent painful urination	diabetes
Elevated cholesterol	pneumonia	frequent tonsillitis	pilonidal cyst	kidney stones	easy bruising / hemophilia
Shortness of breath	heart murmur	glasses / contacts	seizures	menstrual problems	thyroid disorder
Positive TB test	eating disorder	hearing impairment	hepatitis A or B (specify)	pelvic infection	other hormone problems
Abdominal pain	pregnancy	high blood pressure	low vision / eye disease	emotional problems	HIV / AIDS
Migraine headaches	jaundice	excessive worry / anxiety	chronic diarrhea / constipation	urinary tract infection	colitis / rectal bleeding
Mononucleosis	nose bleeds	major depression	injury of extremity	gall bladder problems	rheumatic fever
Back / neck pain	arthritis	sleep disturbance			

Please indicate any medications you are **NOW taking** (including any for emotional/psychological problems): _____

ALLERGIES (important): _____

*Explain allergic reaction (rash, hives, difficulty breathing): _____

Medical conditions that restrict activity or history of chronic medical problems: _____

Have you ever received counseling or psychotherapy? Yes No if yes, please explain: _____

Current physician: Name _____ Phone number: _____

Do you desire follow up treatment by the Wellness Center Staff? Yes No* If yes, please explain: _____

**If you have answered 'No', the Wellness Center will assume all medical problems previously marked are either controlled or no longer a problem.*

PHYSICAL EXAMINATION

Carroll College Wellness Center does not do routine entrance physical examinations. We strongly recommend a thorough physical examination for ALL students prior to entering college. **Athletes are required by the Athletic Department to have a Physical Exam and should return their athletic exams to the Athletic Department.**

CONFIDENTIALITY

Carroll College Wellness Center maintains a close working relationship with other professionals at Carroll. At times the need for more comprehensive healthcare will require limited sharing of information between medical and counseling professionals. Any information disclosed in this manner is subject to HIPAA regulations of confidentiality in accordance with the policies and procedures of the Wellness Center and Carroll College. A copy of our Notice of Privacy Practices is available at the Wellness Center.

Consent for Medical Treatment

The information provided is true to the best of my knowledge. I have read and agree with the confidentiality policy. Carroll College Wellness Center is authorized to perform such medical treatment and procedures that they deem necessary.

Student's Signature _____ Date _____

Parent or Guardian's Signature (if student is under 18 years of age) _____

***For confidentiality reasons, please return Student Immunization Record to: Carroll College Wellness Center, 1601 N Benton Ave., Helena MT 59625**