LEHIGH UNIVERSITY | **IMMUNIZATION RECORD** | 2022/2023

If the immunization requirements are not met, the student will NOT be permitted to obtain their residence hall room key.
Please record dates (month/day/year) below AND include a copy of vaccine records from your medical provider.

NAME _____
Last First Middle

D.O.B. _____/_____/_____
Month Day Year

REQUIRED IMMUNIZATIONS

REQUIRED IMMUNIZATIONS

THIS SECTION MUST BE COMPLETED AND FILLED OUT.
ANY BLOOD TEST REPORT SHOWING IMMUNITY MUST BE ATTACHED.

	1st Dose Date	2nd Dose Date	3rd Dose Date	
1. **Hepatitis B** A 3-shot series is required. First of 3 must have been given prior to enrollment at LEHIGH. A blood test report indicating immunity is acceptable.	M/D/Y	M/D/Y	M/D/Y	
2. **MMR** (Measles/Mumps/Rubella) Two (2) doses **after age 12 months**, given at least 28 days apart. A blood test report indicating immunity is acceptable.	M/D/Y	M/D/Y		
3. **Tdap** (Tetanus/Diphtheria/Pertussis) Vaccine **within 10 years.**	M/D/Y			
4. **Varicella** (Chicken Pox) Two (2) doses **after age 12 months**, given at least 28 days apart. A blood test report indicating immunity is acceptable.	M/D/Y	M/D/Y		
IMMUNIZATONS AFTER AGE 16				
5. **Meningitis** (Serogroup A,C,Y, W135) at least one dose **after age 16.** *Menactra, Menveo or Menomune*	M/D/Y	M/D/Y		
6. **Meningitis B** (Serogroup B) Minimum of two doses are required. Please indicate which brand received. ☐ *Bexsero - 2 dose series* OR ☐ *Trumenba - 2 or 3 dose series*	M/D/Y	M/D/Y	M/D/Y	
COVID-19				
COVID-19 Primary series and booster required. Please indicate which brand received. ☐ *Moderna* ☐ *Pfizer* ☐ *Johnson & Johnson* ☐ _____	M/D/Y	M/D/Y	M/D/Y	

REQUIRED IMMUNIZATIONS

OTHER IMMUNIZATIONS RECEIVED (highly recommended but not required)

Hepatitis A				
HPV (Human Papillomavirus Vaccine)				
Influenza				
Pneumococcal				
Polio				

I certify that to the best of my knowledge the information provided on this form is true and complete.

Date _____ Healthcare Provider's Signature _____

Telephone: (____)_____ Fax: (____)_____

LEHIGH UNIVERSITY **PHYSICAL EXAMINATION** **2022/2023**

*Physical examination required for **ALL incoming students,** MUST be done within one (1) year prior to your first day of class at LEHIGH.*
*Physical Examination required for **ALL varsity athletes,** MUST be done within six (6) months prior to your first day of class at LEHIGH.*

NAME _____ D.O.B. _____/_____/_____
Last First Middle Month Day Year

Examination Date: _____/_____/_____
Month Day Year

Current prescription and nonprescription medication(s) with dosage(s): _____

_____

Medication Allergies: ( )NO ( )YES: _____

Food Allergies: ( )NO ( )YES: _____

History of Anaphylaxis: ( )NO ( )YES, what was the trigger? _____ Does student carry an EpiPen or AuviQ? ( )NO ( )YES

MEDICAL and SURGICAL HISTORY, *please indicate if student has a history of any of the following.*

Anemia	YES	NO	COVID -19	YES	NO	Hypertension	YES	NO	Eating Disorder	YES	NO
Sickle Cell Disease	YES	NO	Inflammatory Bowel Disease	YES	NO	Marfan Syndrome	YES	NO	Skin Condition	YES	NO
Sickle Cell trait	YES	NO	Rheumatoid Arthritis (or JIA)	YES	NO	Headache Disorder	YES	NO	Celiac Disease	YES	NO
Infectious Mononucleosis	YES	NO	Lupus (SLE)	YES	NO	Head injury/Concussion	YES	NO	Immunocompromising condition	YES	NO
Positive PPD or QTB	YES	NO	Diabetes Mellitus	YES	NO	Syncope	YES	NO	ADHD	YES	NO
Active Tuberculosis	YES	NO	Thyroid Disorder	YES	NO	Kawasaki Disease	YES	NO	Anxiety	YES	NO
Asthma	YES	NO	Seizure Disorder	YES	NO	Arrhythmia-WPW, prolonged QT	YES	NO	Depression	YES	NO
									Bipolar Disorder	YES	NO

Provide details for any YES answers: _____

_____

_____

Prior Surgery? ( )NO ( )YES, *provide details*: _____
Prior Hospitalization? ( )NO ( )YES, *provide details*: _____
Please include recommendations that may be important for the care of this student: _____

_____

_____

Physical Examination: BP _____ P _____ HT _____ WT _____ BMI _____ Vision: R 20/_____ L 20/_____

	NORMAL	NOT EXAMINED	ABNORMAL - describe findings
General Appearance			
Head, Eyes, Ears, Nose, Throat			
Lymph Nodes			
Cardiovascular/Pulses			
Respiratory/Lungs			
Gastrointestinal			
Musculoskeletal			
Neurologic			# of Concussions _____
Skin			

REQUIRED FOR VARSITY ATHLETIC PARTICIPATION:

Sickle cell trait testing is **REQUIRED**, *must provide documentation of test results.*

This student is medically cleared for sports participation: ( ) Unlimited ( ) Limited ( ) Not Cleared, *provide details*: _____

_____ ( ) N/A

I certify that to the best of my knowledge the information provided on this form is true and complete.

Physician/Healthcare Provider's Signature _____ MD, DO, NP, PA-C DATE: _____

Office Address: _____

Office Phone: _____

Offfice Fax: _____

OFFICE STAMP