FranklinPierce UNIVERSITY

HEALTH FORMS

Tel (603 899-4130 * Fax (603) 899-1050 * healthservices@franklinpierce.edu

Health Services

IMMUNIZATION FORM

Physical Examination to be completed by MD/NP/PA/DO. **DUE: JULY 15**

MD/NP/PA OR DO TO COMPLETE & SIGN THIS PAGE

Name: ____ Date of Birth:_______________________
LAST FIRST MIDDLE

Address: ____ SSN: _____________________________
STREET ADDRESS CITY STATE ZIP

REQUIRED IMMUNIZATIONS:	Date	Date	Titer / Date
1. M.M.R. (Measles, Mumps, Rubella) Two doses measles required. Dose #2 given at least one month after first dose OR report of positive immune titer			
2. Tetanus-Diphtheria; Required Primary Completed Series Booster within the last 10 years	Td	Tdap	
3. Varicella	Date	Date	Disease/Date
4. Meningococcal Quadrivalent conjugate (required for freshman living in residence halls) or polysaccharide if conjugate is not available. If initial dose given **under age 16 years** a conjugate booster dose is required **>16 - 21 years**.1	Quadrivalent Conjugate # 1/Date:	Quadrivalent Conjugate # 2/Date:	

5. Tuberculosis Screening **(within one year of acceptance to Franklin Pierce University).**

a) Have you been in contact with a person who has TB?	Yes ☐	No ☐
b) Do you have signs or symptoms of active tuberculosis disease?	Yes ☐	No ☐
c) Were you born in another country and arrived in the past 5 yrs.?	Yes ☐	No ☐
d) Are you a1 member of a high-risk group?	Yes ☐	No ☐

If NO, stop here! If YES, place Tuberculin Skin Test (Mantoux only).
A history of BCG vaccination should not preclude testing a member of a high-risk group.

e) Tuberculin Skin Test *(Record of actual MM of induration transverse diameter, if no duration, write "0")*	Date given:	Date read:	Result:
f) Chest X-Ray (required if tuberculin skin test is positive)	Result: Normal ☐	Result: Abnormal ☐	Date of X-Ray:

STRONGLY RECOMMENDED:			
1. Varicella	History of Disease/Date	Vaccine/Date	Antibody/Date
2. Hepatitis B (3 doses of vaccine or Pos. Hep B surface antibody).	#1 ____________ Date:	#2 ____________ Date:	#3 ____________ Date:

____ ______________________________
PROVIDER SIGNATURE **DATE**

Complete and return to Franklin Pierce University, Health Services, 40 University Drive, Rindge, NH 03461, by July 15