Immunization Record

Carroll College

A Student Immunization Record is REQUIRED for ALL new students, including those who are returning after an absence of one calendar year as well as 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 NAME FIRST NAME M.I. STUDENT ID #

Date of Birth: ___/___/___ Gender: ☐ M ☐ F Application Type: ☐ Freshman ☐ Transfer ☐ Readmit

Permanent Address: _____
STREET CITY ST ZIP

Home Telephone #: Student's Local Phone # or Cell Phone #: Email address:

Father's Name: Mother's Name:

Required Immunizations: Transcripts Don't Work

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

MMR (Measles, Mumps, Rubella)		DPT (Diphtheria, Tetanus, Pertussis)					Polio Series				Meningitis Vaccine
Montana requires proof of two MMR's if born after Jan. 1957*		A minimum of three shots; plus Tdap booster within the past **ten years**					Series of 3 doses of live oral polio one after fourth birthday, or two injects				One vaccination required within the past **five years**
MMR #1	MMR #2	DPT #1	DPT #2	DPT #3	DPT #4	Tdap	Polio #1	Polio #2	Polio #3	Polio #4	Meningitis
MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY

Required within one year prior to attendance:

Tuberculosis (Tb, or PPD) Skin Test: Date Given: ___/___/___ **Date Read:** ___/___/___ **Results:** _____

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: 1. ___/___/___ 2. ___/___/___ 3. ___/___/___

Flu Vaccine: ___/___/___

Pneumoccocal Vaccine: ___/___/___

Chicken Pox: Date of Vaccination ___/___/___ Or, Date of Disease ___/___/___ Or, Titre Date ___/___/___ And, Titre Results ___/___/___

To the best of my knowledge, this person has received the above immunizations.

–OR–

A signed copy of immunizations from your high school, previous college, or from your family physician.

Health Care Provider Signature: _____

Title: _____

Date: _____

Immunization Record continued

Carroll College

Family History

(Please check ALL that are in your family history.)

- ☐ Alcoholism
- ☐ Blood Disease
- ☐ Cancer
- ☐ Clinical Depression
- ☐ Diabetes
- ☐ Emotional Problems
- ☐ Heart Disease
- ☐ Hepatitis B
- ☐ Hereditary Disorder
- ☐ High Blood Pressure
- ☐ Migraine
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Tuberculosis
- ☐ Ulcers, Bowel Problems

Personal History

(Please check any medical problems you currently have, or have ever had.)

- ☐ Abdominal Pain
- ☐ Abnormal Pap Smear
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back/Neck Pain
- ☐ Breast Lumps
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic Cough
- ☐ Chronic Diarrhea/ Constipation
- ☐ Colitis/Rectal Bleeding
- ☐ Concussion/Head Injury
- ☐ Congenital Disorders
- ☐ Diabetes
- ☐ Easy Bruising/Hemophilia
- ☐ Eating Disorder
- ☐ Elevated Cholesterol
- ☐ Excessive Weight Gain/Loss
- ☐ Excessive Worry/Anxiety
- ☐ Frequent Colds/ Ear Infections
- ☐ Frequent Sinus Infections/Tonsillitis
- ☐ Hay Fever
- ☐ Hearing/Vision Impairment
- ☐ Heart Murmur
- ☐ Hemorrhoids
- ☐ Hepatitis A or B (specify)
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Injury of Extremity
- ☐ Kidney Stones
- ☐ Loss of Consciousness/ Seizures
- ☐ Tuberculosis
- ☐ Ulcers, Bowel Problems
- ☐ Major Depression/ Emotional Problems
- ☐ Meningitis/Encephalitis
- ☐ Menstrual Problems
- ☐ Migraine Headaches
- ☐ Mononucleosis
- ☐ Nose Bleeds
- ☐ Other Hormone Problems
- ☐ Pelvic Infection
- ☐ Pilonidal Cyst
- ☐ Pneumonia
- ☐ Positive Tb Test
- ☐ Pregnancy
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Sleep Disturbance
- ☐ Thyroid Disorder
- ☐ Tobacco Use
- ☐ Ulcer
- ☐ Urinary Tract Infection

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

Allergies (important):

Please 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: Phone #:

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 exams. We strongly recommend a thorough physical exam 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 enclosed.

Consent for Medical Treatment

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

Carroll College Wellness Center Immunization Registry Release Form

I authorize the Carroll College Wellness Center and the Department of Public Health and Human Services to collect and enter my Immunization Records into the State of Montana Immunization Registry (IMMTRAX). IMMTRAX is a confidential computer system that contains vaccination histories. I understand that this information in the registry may be released to county health departments as well as health care providers across the state that may provide continuing immunization services. I understand that I can revoke this authorization and have my record removed at any time by contacting my local county health department. (Parent signature required if student is under 18 years of age.)

Signature of Student: Date:

(Or Parent/Guardian if student is under 18 years)

Printed Name:

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