

Due date:  
Fall - August 1st; Spring - January 1st

Queen Anne's Building  
300 Washington Avenue  
Chestertown, MD 21620  
Phone 410-778-72 61 Fax 410-810-7101

[REDACTED]

[washcoll.studenthealthportal.com](http://washcoll.studenthealthportal.com)

**\*\*FOR LICENSED HEALTHCARE PROVIDER TO COMPLETE\*\***

TO THE EXAMINING HEALTH CARE PROVIDER: Please review the student's history and complete this report. Please comment on all positive  
*This student has been accepted. The information supplied will not affect his/her status. It will be used as a background for providing*  
*admission to the campus and for student activities including use of the fitness facilities and classes, intramural, club or*

[REDACTED]

ON INFORMATION

Name \_\_\_\_\_ MI \_\_\_\_\_  
 Last First  
 Date of Birth month/day/year social security # Phone

Part II To be completed and signed by a Health Care Provider (Include month, day, year and translate all lab work and results in

English) IMMUNIZATIONS REQUIRED FOR ALL STUDENTS

A. For international students:

1. BCG vaccine received? no \_\_\_ yes \_\_\_ date given \_\_\_ / \_\_\_ / \_\_\_

B. TETANUS-DIPHTHERIA

1. Completed primary series of tetanus-diphtheria immunizations \_\_\_ / \_\_\_ / \_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Received tetanus-diphtheria booster within the last 10 years \_\_\_ / \_\_\_ / \_\_\_  
 or Tdap booster (recommended for ages 11-64 unless contraindicated) \_\_\_ / \_\_\_ / \_\_\_

C. M.M.R. (Measles, Mumps, Rubella)

1. Dose 1 - Immunized at 12 months or before 5 years \_\_\_ / \_\_\_ / \_\_\_  
 2. Dose 2 - Immunized at 4 years or later (at least 28 days after first dose) \_\_\_ / \_\_\_ / \_\_\_

D. POLIO please circle vaccine type: Oral Inactivated

1. Completed primary series of polio immunizations \_\_\_ / \_\_\_ / \_\_\_ Last booster \_\_\_ / \_\_\_ / \_\_\_

E. HEPATITIS B

1. Dose #1 \_\_\_ / \_\_\_ / \_\_\_ Dose #2 \_\_\_ / \_\_\_ / \_\_\_ Dose #3 \_\_\_ / \_\_\_ / \_\_\_  
 OR Surface antibody \_\_\_ / \_\_\_ / \_\_\_ Result: Reactive \_\_\_ Non-reactive \_\_\_

F. MENINGITIS VACCINE (Required by Maryland law for college students)

1. Name of vaccine: \_\_\_\_\_ Date \_\_\_ / \_\_\_ / \_\_\_  
 2. Booster required if original dose given before 16 Date \_\_\_ / \_\_\_ / \_\_\_

G. VARICELLA (Chicken Pox)

Disease? Yes \_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_ if date unknown provide titer results and  
 Reactive (date): \_\_\_ / \_\_\_ / \_\_\_ NonReactive (date): \_\_\_ / \_\_\_ / \_\_\_  
 Vaccine: Dose #1 \_\_\_ / \_\_\_ / \_\_\_ Dose #2 \_\_\_ / \_\_\_ / \_\_\_

STRONGLY RECOMMENDED VACCINES:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

OR  
 COVID vaccine (2-dose): Type \_\_\_\_\_ Date #1 \_\_\_\_\_ Date \_\_\_\_\_  
 AND  
 COVID Booster \_\_\_\_\_ History of having COVID? N/Y-Date \_\_\_\_\_