SOUTHWEST
TENNESSEE COMMUNITY COLLEGE

TENNESSEE'S COMMUNITY COLLEGES

TO THE PHYSICIAN

Following the recommendation of the Director of the Infectious Disease Division of the Memphis and Shelby County Health Department, the following immunizations are required:

A. Tetanus Toxoid – three (3) doses with the final or booster within past 10 years
B. Diphtheria – three (3) doses with the final or booster within past 10 years
C. Polio – three (3) doses of Trivalent Oral Polio Vaccine
D. Tuberculin Skin Test: within 30 days of enrolling in classes at Southwest
E. Two doses Measles
F. Two doses Mumps (men only)
G. Two doses Rubella
H. One dose Varicella (Chicken Pox)

Physician:
Please sign your name at the end of this form and have it typed along with your professional address, telephone number and answering service number. Thank you for your information and compliance with our new standard for health record maintenance.

Immunization Requirements

The student has had three doses of:

A. Tetanus Toxoid Date of final dose within past 10 years_____/____/____

B. Diphtheria Vaccine Date of final dose within past 10 years____/____/_____

C. Polio/Trivalent Oral Date of final dose ____/____/___

D. Tuberculin Skin Test Date ____/____/___ POS.____ NEG.____

The student has had two doses of MMR (Measles, Mumps and Rubella:

A. Date of 1st dose ____/____/___

B. Date of 2nd dose ___/____/____

Known Allergies

Medications _____

Food/Other _____

Activity Exemption

List any condition/disability that would permanently limit the student's activity

_____

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Physical Exam

Name _____ Age _____ Sex _____

Date of Exam _____ Height _____ Weight _____ BP _____ Pulse_____

	Normal/Abnormal	Comments
ENT		
Head/Neck		
Chest		
Heart/Lungs		
Abdomen		
GI		
GU		
Skeletal		
Extremeties		
Hernia		
Menstrual		
Dental		
Hematocrit		
Urinalysis	Sp. Gr./Albumin/Sugar	Micro

Emotional Stability: Remarks _____

Any further comments on this student's physical and/or emotional ability to undertake a college career?

_____

Physician's signature _____

Physician's name (please print or type) _____

Professional address _____

Office telephone _____