Immunizations Required by Vermont Law

1. You must be up-to-date with the 5 immunizations, as outlined in the table below.

2. **Obtain an official copy of your Immunization Record (and a Request for Provisional Admittance, if requirements not yet met) from your health care provider, and upload it through the Health Portal.**

3. Students who have no record of immunizations or have incomplete immunizations must submit a Request for Provision Admittance form (in this packet).

4. In rare cases, you will not be able to obtain a record of immunizations. In that case, try to obtain these records from previously attended schools or from your State Immunization Registry. Blood tests can be obtained to determine immunity.

5. Please have your health care provider review these guidelines.

6. **According to the Vermont law, students who do not meet the Vermont immunization requirements must be excluded from school. Failure to upload required forms by the deadlines may result in exclusion from campus, room key holds, and registration holds.**

The following requirements MUST BE MET:

Vermont State Requirements	
HEPATITIS B	3 Doses • Minimum 1 month between doses 1 and 2 • Minimum 2 months between doses 2 and 3 • Minimum 4 months between doses 1 and 3 **OR** Positive Titer
MENINGITIS (ACWY or MPSV4) • (Meningitis B is optional)	One dose, given **after 16th birthday** • **If first dose given before 16th birthday, must have 2nd dose**
MMR	2 doses: MMR, *MMRV or Individual Vaccines • First dose given **AFTER** first birthday • At least 4 weeks between doses **OR** Positive Titers *MMRV : Measles / Mumps / Rubella / Varicella
TETANUS (with Diptheria AND Pertussis)	1 dose: Tdap (Tetanus, Diptheria, and Pertussis) **Must be Tdap.** • NOT ACCEPTED: Td, Dtap, or DT
VARICELLA	2 doses: Varicella or MMRV • First dose given **AFTER** first birthday • At least 4 weeks between doses **OR** Positive Titer **OR** History of disease (document on Varicella disease form)

Request for Provisional Admittance

Prior to college entry, Vermont's Immunization Rule requires that students have certain immunizations. Exemptions exist for medical or religious reasons. Students are allowed provisional admittance temporarily IF the student has an appointment scheduled to receive the missing vaccine(s), consistent with the Centers for Disease Control and Prevention (CDC) immunization schedule. Please bring this form to your health care provider for completion. Please upload this completed form with your Immunization record to date.

_____ _____ _____

Student first/last name Date of Birth MC ID#

Failure to comply with the Immunization Rules will result in exclusion from Middlebury College.

The student named above is in the process of completing vaccine requirements. Vaccination Appointment(s) scheduled as follows:

Vaccines scheduled:

Vaccine	Dose(s) Missing	Scheduled appointments
Hepatitis B	1 2 3	(mm/dd/yy) ____/____/_____(mm/dd/yy) ____/____/____
Measles, Mumps, Rubella (MMR)	1 2	(mm/dd/yy) ____/____/____
Varicella (Chicken Pox) (*Or documentation of disease)*	1 2	(mm/dd/yy) ____/____/____
Meningococcal (A,C,W,Y) *(dose required after age 16 yo)*	1	(mm/dd/yy) ____/____/____
Tdap within 10 years *(one dose after completion of childhood series, then Td within 10 years)*	1	(mm/dd/yy) ____/____/____

Upon vaccination, the student will be provided documentation and advised to submit the updated immunization record to the Parton Health Center at Middlebury College. (Fax # 802-443-2066)

_____ _____

Print Name of Health Care Provider Signature of Health Care Provider

Date: ___/___/___ Telephone Number_____

Updated 4 19 18, 5/1/18 s robinson

STUDENT NAME: _____ DOB: _____

HEALTHCARE PROVIDER FORM

TO BE COMPLETED BY A HEALTH CARE PROVIDER (not a family member) and *SIGNED AT THE BOTTOM*

1. PHYSICAL EXAM

B/P:	Pulse:	Ht:	Wt:	BMI:	(Corrected) Vision: L 20/ R 20/

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance - Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, myopia, VPS, aortic insufficiency)		
Eye/ears/nose/throat. *Pupils Equal *Hearing wnl		
Lymph nodes		
Heart -Murmurs (auscultation standing, supine, +/- valsalva) -Location of PMI (Consider ECG, echo, and/or referral to cardiology for abnormal cardiac history or exam)		
Pulse - Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin - HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL		
Back/Neck		
Shoulder/Arm/Elbow/Forearm/ Wrist/Hand/Fingers		
Knee/Hip/Thigh/Leg/Ankle/Foot/Toes		
Functional - Duck-walk, single leg hop		

ANY OTHER HEALTH-RELATED ISSUES / UNDER TREATMENT FOR ANY MEDICAL OR PSYCHIATRIC CONDITIONS?

- PLEASE ATTACH COPIES OF ALLERGY AND ASTHMA ACTION PLANS FOR STUDENTS WITH ASTHMA / ALLERGIES, **CRITICAL TEST RESULTS, OPERATIVE NOTES, AND CLEARANCE FOR ACTIVITY FROM SPECIALISTS FOR PRIOR CARDIAC, ORTHOPEDIC, OR OTHER MAJOR MEDICAL ISSUES.**
- MENTAL HEALTH SERVICES FOR STUDENTS WITH EATING DISORDERS ARE LIMITED IN OUR REGION.
- ***ADD / ADHD:*** **STUDENTS TAKING MEDICATION FOR ADD/ADHD WILL NOT BE ABLE TO OBTAIN PRESCRIPTIONS FOR REFILLS FROM PARTON HEALTH SERVICE.PLEASE MAKE ARRANGEMENTS FOR REFILL PRESCRIPTIONS DIRECTLY WITH YOUR PATIENT.**

2. NCAA REQUIREMENT SICKLE CELL TRAIT STATUS, HgbAS: FOR INTERCOLLEGIATE ATHLETICS, CLUB RUGBY, CLUB CREW

Please check the appropriate box below, and provide patient with a copy of either Newborn HgbAS screening result **OR** a recent HgbAS test result.

☐ **HgbAS Positive** ☐ **HgbAS Negative** ☐ **Declines HgbAS Test**

3. ACTIVITY CLEARANCE:

☐ **CLEARED FOR ALL ACTIVITIES.** I have reviewed this patient's personal health history and completed the physical exam. The patient is cleared for full athletic participation without restriction.

☐ **NOT CLEARED:** ☐ pending further evaluation ☐ for any activities or athletics ☐ for certain activities /athletics

REASON: _____

RECOMMENDATION: _____

Please advise your patient about any concerns you have regarding clearance for athletic activities.

Name of Health Care Provider (print)_____ Phone:_____ Fax:_____

Address:_____City: _____State:_____ Zip:_____

Signature: _____Date of Exam: _____

Updated 4 19 18, 5/1/18 s robinson

New Student Attestation and Consent Form

My signature below indicates that:

1. I consent to medical and nursing treatment by the Middlebury College Parton Health Service staff.
2. The information on my submitted health forms is correct and complete to the best of my knowledge.
3. I have read the Commitment to Confidentiality.
4. I understand Parton Health Service is required by state law to report positive results of certain laboratory tests to the Vermont Department of Health.
5. I authorize Parton Health Service to contact my health care provider about any information missing from my submitted medical examination or immunization record.
6. If I require specialist services, lab testing, x-rays, prescriptions, or other referrals beyond the primary care services available at Middlebury College Parton Health Service, I shall assume the financial responsibility or negotiate satisfactory arrangements with the caregiver.

Signature of Student_____Date_____

Print Name: _____DOB: _____

Signature of parent/guardian_____ Date_____

(Required if student is not yet 18 years old or if insurance is in parent's or guardian's name.)

MIDDLEBURY COLLEGE
Parton Health Services

Physician/Provider Tuberculosis (TB) Form

Name: _____ Date of Birth:_____ College ID#: _____
Last First

This form is required of all students who:

- indicated on their health form that they have had potential exposure to TB through contact with high risk people, environments, or situations
- were born in or have traveled to high risk countries (according to CDC guidelines)

Instructions for Physician/Provider:

1. TB Skin Test (TST) **OR** Interferon-Gamma Release Assay (IGRA) is required
   a. A history of BCG vaccination does not preclude testing
   b. Unlike TST, IGRA is not influenced by prior BCG vaccination

2. If TST or IGRA is positive, Chest X-ray is required.

TST: Date Placed: _____ Date Read: _____ Result: _____mm induration

OR

IGRA: Date: _____ Result: ☐ Negative ☐ Positive
☐ Indeterminate ☐ Borderline (T-Spot only)

Chest X-ray results: (If positive TST or IGRA)

Date of X-ray: _____Result: ☐ Normal ☐ Abnormal

Signature of Health Care Provider: _____ Date:_____

Name of Health Care Provider (Print) _____

Address_____

City _____State _____Zip _____

Phone: (_____)_____ Fax: (_____)_____

Updated 4 19 18, 5/1/18 s robinson