Immunization Record and Medical Clearance for Minnesota State University Athletic Training Students

(Examinations for ATHLETIC TRAINING STUDENTS must be completed by a Physician-MD/DO)

Name:_____ _____/____/_____
(last) (first) (m) (date of birth)

Immunization Record Verification: Minnesota Law (M.S. 135A.14) requires that all students born after 1956 and enrolled in a public or private post-secondary school in Minnesota be immunized against diphtheria, tetanus, measles, mumps, and rubella, allowing for certain specified exemptions. However, the athletic training program requires all athletic training students to maintain a program of yearly health examinations and immunizations. Documentation of vaccinations are required for final program admission and all athletic training students must provide documentation prior to starting required clinical experiences.

Required Immunizations:

MMR (Measles, Mumps, Rubella)[#] **Month:**_____**Day:**_____ **Year:**_____
[#]Most recent dose required at or after 12 months of age.

Tdap (Tetanus, diphtheria, pertussis)[1] **Month:**_____**Day:**_____**Year:**_____
[1]Most recent dose required within past 10 years.

TB screening/Mantoux (within 12 months)[@] **Month:**_____**Day:**_____**Year:**_____
[@] Or evidence of recent chest x-ray or serologic testing indicating the presence of antibodies.

Varicella (chicken pox)**** **Month:**_____**Day:**_____**Year:**_____
**** Or evidence of serologic testing indicating the presence of antibodies.

Hepatitis B* dose (final) 3 **Month:**_____**Day:**_____**Year:**_____
*Health care professionals and students who perform tasks that may involve exposure to blood or body fluids must obtain anti-HBs serologic testing 1-2 months after dose 3:
Month:_____**Day:**_____**Year:**_____

Medical Exemption: The student named above lacks one or more of the required immunizations because he/she has:
- a medical problem that precludes the _____ vaccine
- has not been immunized because of a history of _____ disease
- has laboratory evidence of immunity against _____ disease

Summary of defects and diagnosis: _____
_____

Medications currently prescribed, etc: _____

Drug Allergies: _____

CHECK REGARDING WORK IN A HEALTH CARE SETTING, INCLUDING LIFTING:

_____ NO RESTRICTIONS _____SPECIFIC RESTRICTIONS _____COMPLETE RESTRICTIONS

SUGGESTED RESTRICTIONS OR RECOMMENDATIONS FOR REASONABLE ACCOMMODATIONS, IF ANY:

Note that conscious exemption may preclude students from obtaining some required clinical experiences, therefore will negatively impact the student's ability to complete all program requirements.**In addition this form must be completed even if another is provided by the physician.**

To my knowledge the above information is accurate and complete:

Physician's Name (Print): _____
Address:_____
City: _____ **State:** _____ **Zip:** _____**Telephone:** _____

Physician's Signature_____**Date**_____

Please return this completed form or direct questions to:

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