



**Taylor Health and Wellness Center**  
 Missouri State University  
 901 South National  
 Springfield, MO 65897  
 (417) 836-4000 (phone) / (417) 836-4133 (fax)

TO THE STUDENT: A physical examination is **not required**. To assist Taylor Health & Wellness in providing quality care, if you have had a significant medical problem or your physician / provider would like to send information about your medical history, please send it to the above stated address. Your **medical records are confidential** and will not be released without your signed consent.

**NAME** \_\_\_\_\_ **SSN** \_\_\_\_\_

Last                                      First                                      Middle

**I. Please record your immunization history below.** It is extremely important that this document be returned to Taylor Health and Wellness Center when completed.

IMMUNIZATIONS									
(A copy of your personal record is acceptable)									
	DATE	DATE	DATE	DATE	DATE		DATE	DATE	DATE
DTP						Hepatitis A			
Td						Hepatitis B			
Tdap						Twinrix (combination Hep A & B)			
Polio						Typhoid			
MMR (2)						BCG (TB vaccination)			
Measles Booster (Rubeola)						Pneumococcal			
Varicella						Meningococcal			
Smallpox									

**II. Tuberculin Skin Test**     Positive     Negative    Date \_\_\_\_\_

If **positive** skin test, was chest x-ray completed?     Yes     No    (Please provide copy of x-ray results.)

INH Treatment?     Yes     No    Date \_\_\_\_\_