LEHIGH UNIVERSITY | **IMMUNIZATION RECORD** | 2025/2026

If the immunization requirements are not met, the student will NOT be permitted to obtain their residence hall room key.
Please record dates (month/day/year) below AND include a copy of vaccine records from your medical provider.

NAME Bousum (Last) Cooper (First) B (Middle)

D.O.B. 5 / 13 / 2007 (Month / Day / Year)

REQUIRED IMMUNIZATIONS

THIS SECTION MUST BE COMPLETED AND FILLED OUT.
ANY BLOOD TEST REPORT SHOWING IMMUNITY MUST BE ATTACHED.

	1st Dose Date	2nd Dose Date	3rd Dose Date	4th Dose Date
1. **Hepatitis B** A three (3) dose series is required. A blood test report indicating immunity is acceptable. *Alternative 2 dose series* ☐ *HEPLISAV-B*	5/13/07	7/12/07	11/30/07	
2. **MMR** (Measles/Mumps/Rubella) Two (2) doses **after age 12 months**, given at least 28 days apart. A blood test report indicating immunity is acceptable.	5/16/08	6/3/2011		
3. **Tdap** (Tetanus/Diphtheria/Pertussis) Vaccine **within 10 years.**	6/22/18			
4. **Varicella** (Chicken Pox) Two (2) doses **after age 12 months**, given at least 28 days apart. A blood test report indicating immunity is acceptable.	8/8/08	10/13/11		
IMMUNIZATONS AFTER AGE 16				
5. **Meningitis** (Serogroups A,C,Y, W135) at least one (1) dose **after age 16.** *MenQuadfi, Menactra, Menveo or Menomune*	3/14/24	10/7/19		
Both Meningitis and Meningitis B are required immunizations				
6. **Meningitis B** (Serogroup B) Two (2) doses are required. Please indicate which brand received. ☑ *BEXSERO - 2 dose series (6 months apart)* OR ☐ *TRUMENBA - 2 dose series (6 months apart)*	7/1/24			
Alternative Meningitis (Serogroups A, B, C, W, and Y) ☐ *PENBRAYA* *Second dose of **Trumenba** required after 6 months.* Alternative Meningitis (Serogroups A, B, C, W, and Y) ☐ *PENMENVY* *Second dose of **Bexsero** required after 6 months.*				

OTHER IMMUNIZATIONS RECEIVED (highly recommended *but not required*)

COVID-19 (✓Moderna (✓)Pfizer ( )Johnson & Johnson ( )_____	5/14/21	6/4/21	1/10/22	10/13/23
Hepatitis A	11/17/08	5/29/09		
HPV (Human Papillomavirus Vaccine)	2/24/21	8/24/21		
Influenza	10/13/23			
Polio	7/12/07	11/30/07	2/8/08	6/3/2011

I certify that to the best of my knowledge the information provided on this form is true and complete.

Healthcare Provider's Signature _____ Date: 6/11/25

Telephone: 877-379-5522

Fax: 978-948-5200

[Office Stamp]

LEHIGH UNIVERSITY **PHYSICAL EXAMINATION** **2025/2026**

*Physical Examination required for **ALL incoming students**, MUST be done **within one (1) year** prior to your first day of class at LEHIGH.*
*Physical Examination required for **ALL varsity athletes**, MUST be done **within six (6) months** prior to your first day of class at LEHIGH.*

NAME Bousum (Last) Cooper (First) _____ (Middle) D.O.B. ____/____/____ (Month/Day/Year)

Examination Date: 3 / 19 / 2025 (Month/Day/Year)

Take any medications? If yes, please list med, dose, frequency. (✓) NO ( ) YES _____

Any allergies (medicine, food, environmental)? (✓) NO ( ) YES, explain: _____

History of Anaphylaxis? (✓) NO ( ) YES, what was the trigger? _____ **Does student carry an EpiPen or AuviQ?** ( ) NO ( ) YES

MEDICAL HISTORY? _____

SURGICAL HISTORY? Ø

Any general comments or recommendations that may be important for the care of this student? In excellent health, NO concerns

Physical Examination: BP 98/54 P 74 HT 6'0.5" WT 165 BMI 22.07 Vision: R 20/____ L 20/____

	NORMAL	NOT EXAMINED	ABNORMAL - describe findings
General Appearance	✓		
Head, Eyes, Ears, Nose, Throat	✓		
Lymph Nodes	✓		
Cardiovascular/Pulses	✓		
Respiratory/Lungs	✓		
Gastrointestinal	✓		
Musculoskeletal	✓		
Neurologic	✓		# of Concussions _____
Skin	✓		

REQUIRED FOR VARSITY ATHLETIC PARTICIPATION:

NCAA requires confirmation of sickle cell trait status for all athletes, documentation of test results must be provided and uploaded.

This student is medically cleared for sports participation: (✓) Unlimited ( ) Limited ( ) Not Cleared, provide details: _____ ( ) N/A

Please be sure to have this section completed if you plan to participate in or try out for varsity sports at any point during your time here on campus.

I certify that to the best of my knowledge the information provided on this form is true and complete.

Physician/Healthcare Provider's Signature _____ MD, DO, NP, PA-C DATE: 6/11/25

Office Address: 414 Haverhill St Rowley MA 01969
Office Phone: 877-379-5522
Office Fax: 978-948-5200

North Shore Physicians Group
414 Haverhill Street
Rowley, MA. 01969