Student Name _____ Date Of Birth _____

PHYSICAL EXAMINATION (acceptable within one year of starting classes)

To be completed by a **medical healthcare provider**: Please review the student's history and complete this form. Comment on all positive answers. The information supplied will be used as a background for providing health care. This information is strictly for the use of the Student Health Center and will not be released without student consent.

BP ____/____ Pulse _____ Height _____ inches Weight _____lbs. BMI_____

Visual Acuity: Right 20/ _____ Left 20/_____ with correction _____; without correction _____

Medication Allergies: _____

Food Allergies_____

Current Medications: _____

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
1. SKIN			10. HERNIA		
2. HEAD, EARS, EYES (Fundoscopic exam), NOSE, THROAT			11. BACK/SPINE		
3. MOUTH, TEETH, GUMS			12. EXTREMITIES/ MUSCULOSKELETAL		
4. NECK AND THYROID			13. NEUROLOGIC		
5. LUNGS/CHEST			14. EMOTIONAL/ PSYCHOLOGICAL		
6. BREASTS **(optional)**			15. Lymph Nodes		
7. HEART			16. Peripheral Vascular		
8. ABDOMEN			17. OTHER FINDINGS		
9. GENITALIA **(optional)**					
Please provide comments regarding any abnormalities:					

Recommendation for physical activities, including participation in club, intramural & intercollegiate sports:

⬜ Unlimited ⬜ Limited If limited, please explain:_____

This student is able to meet the physical and emotional demands of college life: ⬜ Yes ⬜ No If No, please explain:

_____

Signature of Healthcare Provider _____ Date _____

Healthcare Provider Stamp:

Student Name _____ Date Of Birth _____

IMMUNIZATION RECORD
To be completed by a licensed Medical Healthcare Provider
All information must be completed in English

REQUIRED IMMUNIZATIONS

MMR (measles, mumps, and rubella):
Date 1: ___/___/___ Date 2: ___/___/___
Immunization with two doses of MMR, given on or after the first birthday and separated by at least one month.

Reactive antibody titer (IGg) proving active immunity is required for students in **Clinical Health Profession Programs**. **Attach lab results**. If non-reactive, an MMR booster is required, followed by a repeat IgG titer one month afterwards.

TETANUS/DIPHTHERIA/PERTUSSIS:
Date 1: ___/___/___ Date 2: ___/___/___
Date 3: ___/___/___ Tdap Booster: ____/___/____

Three doses of tetanus/diphtheria/pertussis are required with a booster given within the past ten years.

POLIO:
Date1: ___/___/___ Date 2: ____/___/___
Date 3: ___/___/___

Three does; Booster only if needed for travel.

VARICELLA VACCINE (Chicken Pox):
Date 1: ___/___/___ Date 2: ___/___/___

Two properly spaced doses of varicella vaccine or laboratory evidence of immunity.
History of Varicella disease (Chickenpox) alone is not acceptable.

HEPATITIS B:
Date 1: ___/___/___ Date 2: ___/___/___
Date 3: ___/___/___
Series of 3 doses; 0, 1- 2, 6-12 months.

Reactive Surface Antibody Titer (IGg) is required once the series is completed to prove immunity for **Clinical Health Professional Programs**. If the IgG titer is non-reactive, the Hep B series will need to be repeated, with a repeat IgG titer one month after the last vaccine. **Attach lab results.**

TUBERCULOSIS TESTING (within the past year) -
Recommended for all students; REQUIRED for:
• Education Majors and Clinical Health Professional Program
• Anyone who has lived in or visited South America, Central America, Easter Europe, Asia or Africa in the last 5 years
• Students in contact with a known case

TUBERCULOSIS TESTING (PPD)
Date: __/__/__ Result: ⬜Neg ⬜Pos
Induration _____mm
If required: chest x-ray results:
⬜Normal ⬜Abnormal
(M/D/Y/) _____
Official copy of report is Required

A QuantiFERON-TB Gold (QTF) or T-Spot test is the recommended method for TB infection screening.
***PPD's will only be accepted for low risk students in the education program.**

QUANTIFERON GOLD/T-SPOT TEST RESULT (Attach lab result)
Date:__/__/__
Result: ⬜Negative ⬜Normal ⬜Positive/Abnormal

If required: chest x-ray results:
⬜Normal ⬜Abnormal
(M/D/Y/) _____

Student Name _____ Date Of Birth _____

A chest x-ray is required if the student has a positive PPD or QuantiFERON Gold result. An official copy of the chest x-ray report is required.
If the student has had a positive tuberculin skin test or Quantiferon-Gold result, did he/she receive prophylactic medication treatment for Latent TB Exposure? ⬜Yes ⬜No **Please provide medical documentation of this course of treatment from your medical provider.**
If Yes, please indicate medication(s) prescribed _____; dosage_____; Treatment start/end dates: _____

MENINGOCOCCAL QUADRIVALENT VACCINE (A, C, Y, W-135):
Date 1: ___/___/___ Date 2: ___/___/___ ⬜Menomune ⬜Menactra ⬜Menveo
PA State Law requires students living in campus housing to have documentation of a dose of conjugated vaccine. Vaccination is recommended at 11-12 years of age with a booster at/after age 16 **Meningococcal vaccine is required for all Clinical Health Profession students.**
⬜DECLINE: I have read the enclosed information about Meningococcal Meningitis vaccine; however, I decline the vaccine at this time.
I understand that in declining this vaccine, I continue to be at risk for this serious disease. If the student is under the age of 18, parental consent is necessary.

_____ _____ __/__/__
Student Signature Date Parent Signature (if under 18) Date

RECOMMENDED IMMUNIZATIONS

COVID-19 VACCINE: Primary Series
Date 1: ___/___/___Date 2: ___/___/___ BRAND: ⬜Moderna ⬜Pfizer ⬜ AstraZeneca ⬜Johnson & Johnson
(Typically required for all Clinical Health Profession students). ⬜Other_____

Booster 1: ___/___/___ BRAND: ⬜Moderna ⬜Pfizer ⬜ AstraZeneca ⬜ Johnson &
Booster 2: ___/___/___ Johnson ⬜Other_____

Annual Influenza Vaccine (Typically required for all Clinical Health Profession students).

HEPATITIS A VACCINE:
Date 1: ___/___/___ Date 2: ___/___/___ Series of 2 doses; 0, 6 months

MENINGOCOCCAL B VACCINE:
Date 1: ___/___/___ Date 2: ___/___/___ ⬜Bexsero ⬜Trumenba
Date 3: ___/___/___

HUMAN PAPILLOMAVIRUS VACCINE:
Date 1: ___/___/___ Date 2: ___/___/___ Date 3: ___/___/___

ADDENDUM FORMS FOR CLINICAL HEALTH PROFESSION PROGRAM STUDENTS:
SURFACE ANTIBODY TITERS & TB SCREENING RESULTS