Name: ____

Cell : (Student)____________________________________

STUDENT HEALTH SERVICES

PHYSICAL EXAMINATION
IMMUNIZATION RECORD

THESE FORMS ARE MANDATORY AND DUE BY AUGUST 1

PLEASE UPLOAD COMPLETED FORMS
TO YOUR STUDENT HEALTH PORTAL

https://marywood.medicatconnect.com/login.aspx

PHYSICAL EXAMINATION

*****This section is to be completed and signed by an MD, DO, PA-C, or a NP*****

Last Name	First	Middle	Sex
Blood Pressure ____/____	Pulse ____/____	Height ______	Weight ______
Visual Acuity	(R) 20 / _____	(L) 20 / _____	

SYSTEMS REVIEW

	Normal	Abnormal	Describe Abnormalities
Skin			
HEENT			
Lymph Nodes			
Neck			
Heart			
Lungs			
Respiratory			
Gastrointestinal			
Genitourinary			
Reproductive			
Endocrine			
Musculoskeletal			
Neuro/Psych			

GENERAL COMMENTS:

Is there any loss or seriously impaired function of any paired organ? Yes _____ No _____

Recommendations for physical activity (PE, Intramurals)

Unlimited _____ Limited _____ Explain: ____

Do you have any recommendations regarding the care of this patient? ____

Is this patient now under treatment for any medical or emotional condition?____

This patient is free of communicable disease Yes ❑ No ❑

HEALTH PROVIDER'S SIGNATURE ____MD ❑ DO ❑ PA-C ❑ NP ❑

DATE OF PHYSICAL EXAM ____

Health Provider's Name (please print) ____

Address: ____

Telephone Number: (______) - ____________________ Fax: (______) - ____________________

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IMMUNIZATION RECORD

This section is to be completed and signed by an MD, DO, PA-C, or a NP
Day, month and year must be completed.

____
Last Name First Middle

IMMUNIZATIONS MUST BE UPDATED AS SPECIFIED BELOW.

A. TETANUS-DIPHTHERIA

1. ❑ Completed primary series of tetanus-diphtheria immunizations . . . . ______/______/______
2. ❑ Received diphtheria, pertussis, tetanus booster within the last 10 years . . . . Td:______/______/______
Tdap:______/______/______

B. M.M.R. (Measles, Mumps, Rubella)

1. ❑ Dose 1 - Immunized at 12 months . . . . ______/______/______
2. ❑ Dose 2 - Immunized at 4-6 years and at least one month after first dose . . . . ______/______/______

C. Hepatitis B Vaccine (three doses or a positive Hepatitis B surface antibody titer meets the requirement).

❑ Dose 1 . . . . ______/______/______
❑ Dose 2 . . . . ______/______/______
❑ Dose 3 . . . . ______/______/______

D. Varicella

❑ History of disease . . . . ______/______/______
❑ Vaccine Dates: Dose 1 …..……. ______/______/______ Dose 2 . . . . ______/______/______

E. Tuberculosis Screening (PPD regardless of prior BCG inoculation). A two step, within a 3-week interval, is required for all Nursing, Nutrition/Dietetic, Athletic Training, and Physician Assistant Students in **sophomore year**.

1. PPD (Mantoux) Test within the past year (**Tine or monovac not acceptable**).
PPD #1 Date Given: ______/______/______ Result: : ❑ Positive ❑ Negative
PPD #2 Date Given: ______/______/______ Result: : ❑ Positive ❑ Negative
2. **Positive PPD – Chest x-ray required. Must submit a copy of the chest x-ray reading.**

F. Polio

❑ Completed primary series of polio immunizations: ______Yes ______ No
❑ Type of vaccine: ______ Oral ______ Inactive ______ E-IPV
❑ Last Booster . . . . ______/______/______

G. Meningitis – Pennsylvania law mandates that ALL students living in university owned housing be immunized or sign a waiver after receiving information on the disease and vaccine.

❑ Vaccine1 ______/______/______ ❑ Vaccine 2 ______/______/______

H. Influenza . . . . ______/______/______

HEALTH CARE PROVIDER

Name: ______________________________ Address: ______________________________

Signature: ______________________________ **MD** ❑ **DO** ❑ **PA-C** ❑ **NP** ❑ Phone: ( ) ____________________