

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: (_____) - _____

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: () _____