Due date:
Fall – July 15th : Spring – January 1st

Queen Anne Building
300 Washington Avenue
Chestertown, MD 21620
health_services@washcoll.edu
washcoll.studenthealthportal.com
PH: 410-778-7261 Fax: 410-810-7101

1st YEAR STUDENT PHYSICAL FORM

*****For Licensed Providers to Complete*****

TO THE EXAMING HEALTH CARE PROVIDER: Please review the student's history and complete this report. Please comment on all positive answers. *This student has been accepted.* The information supplied will not affect his/her status. It will be used as a background for providing continued physical and mental health care on campus. ***Physical Exam must be done witihin 6 month prior to arriving on campus.***

Name_____**DOB**_____**Current Gender Identity**_____

Height_____**Weight**_____**Blood Pressure**_____**Pulse**_____

Allergies_____

Current Medications_____

_____

Visual Acuity: Recommended

☐ **With** ☐ **Without Correction**

☐ **Glasses** ☐ **Contact Lenses**

Right 20/ **Left 20/** **Both 20/**

Clinical Evaluation	Normal	Record Abnormal Findings
Appearance (Report Marfan Stigmata)		
Skin		
Head, Ears, Eyes, Nose,Hearing		
Mouth, Teeth & Gums		
Neck & Thyroid		
Lungs/ Chest		
Breasts		
Heart (supine & standing)		
Abdomen		
Genitalia		
Back / Spine		
Extremities / Musculosketal		
Neurologic		
Emotional / Psychological		

A. Is this student cleared for physical activity including use the fitness facilities and classes, intramural, club or intercollegiate sports and able to meet the physical and emotional demands of college life include studying abroad? ☐ **YES** ☐ **NO – Limited Explain**_____

Sickle Cell Screen Required for all Varsity Athletes test date_____ ☐Positive ☐Negative

B. Tuberculosis (TB) Screen Required for all Students- Any signs or symptoms of active TB disease?

☐ **NO** – Is this student a member of a high risk group or an International student from a high risk country as defined by the CDC?

☐ **YES --**Proceed with additional evaluation to exclude active TB disease including PPD testing, IGRA, CXR and sputum evaluation as indicated, copies of results must be attached.

C. Is this student under care (by any provider) for any physical or emtional condition?

☐ **NO**

☐ **YES** – describe_____

Surgeries_____**Dietary Restrictions**_____

I have reviewed the medical history, immunizations, conducted the TB screen and examined this student. The information on this form is accurate, full and complete to the best of my knowledge.

Health Care Provider Signature_____**Date:**_____
Print Provider's Name_____**Phone**_____**Fax**_____
Office Address_____

TUBERCULOSIS SCREENING AND IMMUNIZATIONS INFORMATION

NAME_____
LAST FIRST MI

DATE OF BIRTH_____
MONTH/DAY/YEAR SSN PHONE

To be completed and signed by a Health Care Provider (include month, day year, and translate all lab work and results in English)

IMMUNIZATIONS REQUIRED FOR ALL STUDENTS

A. FOR INTERNATIONAL STUDENTS ONLY.
1. BCG vaccine received. No_____ Yes_____Date given_____/_____/_____

B. TETANUS-DIPTHERIA
1. Completed primary series of tetanus-diphtheria immunizations _____/_____/_____
2. Received tetanus-diphtheria booster **within the last 10 years** _____/_____/_____ or Tdap booster (recommended for ages 11-64 unless contraindicated) _____/_____/_____

C. MMR (Measles, Mumps, Rubella)
1. Dose 1 – Immunized at 12 months or before 5 years _____/_____/_____
2. Dose 2 – Immunized at 4 years or later (at least 28 days after first does) _____/_____/_____

D. POLIO, please circle vaccine type: Oral Inactivated
1. Completed primary series of polio immunizations _____/_____/_____

E. Hepatitis B
1. Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____

OR Surface antibody _____/_____/_____ Result: Reactive _____Non-reactive_____

F. MENINGITIS VACCINE "A, C, Y, W" (Required by Maryland law for college students)
1. Name of vaccine: _____Date _____/_____/_____
2. Booster required if original dose given before 16. Date _____/_____/_____

G. VARICELLA (CHICKEN POX)

H. Disease? Yes_____Date:_____/_____/_____ if date unknown provide titer resultsReactive(date): _____/_____/_____

NonReactive(date): _____/_____/_____

Vaccine: Dose #1 _____/_____/_____ Dose #2_____/_____/_____

RECOMMENDED

***COVID VACCINE:** COVID vaccine (1 dose): Type_____ Date_____

COVID vaccine (2-dose): Type_____ Date #1_____ Date #2_____

COVID Booster Type: _____ Date_____

***HEPATITIS A**
Immunizations (Hepatitis A) Dose #1_____/_____/_____ Dose #2 _____/_____/_____
Immunizations (Combined Hepatitis A and B)
Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____

****HUMAN PAPILLOMAVIRUS VACCINE (HPV)**
Name of Vaccine: _____
Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____

*****MENINGITIS B VACCINE**
Name of Vaccine: _____
Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____

Health Care Provider Signature_____**Date**_____

Address_____**Phone**_____