



Due date:  
Fall - July 15th; Spring - January 1st

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## STUDENT HEALTH FORM

**\*\*FOR LICENSED HEALTHCARE PROVIDER TO COMPLETE\*\***

TO THE EXAMINING 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 within 6 months prior to arriving on campus.**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ 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 and Gums		
Neck and Thyroid		
Lungs/Chest		
Breasts		
Heart (supine and standing)		
Abdomen		
Genitalia		
Back/Spine		
Extremities/Musculoskeletal		
Neurologic		
Emotional/Psychological		

**A** Is this student cleared for physical activity including use of 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- 1. Any signs or symptoms of active TB disease?  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.

No → 2. 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-CXR required, copy of results is required and all Treatment Plans for positive findings (including information about INH Therapy) must be attached.  No- No further TB testing required

**C** Is this student under care (by any provider) for any physical or emotional conditions?  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. Sign \_\_\_\_\_ Date \_\_\_\_\_

Print Provider's Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Office Address \_\_\_\_\_

## TUBERCULOSIS SCREENING AND IMMUNIZATION INFORMATION

Name \_\_\_\_\_  
 Last First MI  
 Date of Birth \_\_\_\_\_  
 month/day/year social security # Phone

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

### IMMUNIZATION REQUIRED FOR ALL STUDENTS

#### A. for international students only

1. BCG vaccine received? no \_\_\_ yes \_\_\_ date given \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

#### B. TETANUS-DIPHTHERIA

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. M.M.R. (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 dose) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

#### D. POLIO please circle vaccine type: Oral Inactivated

1. Completed primary series of polio immunizations \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Last booster \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

#### E. HEPATITIS B

1. Dose #1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose #3 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

OR Surface antibody \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Result: Reactive \_\_\_\_\_ Non-reactive \_\_\_\_\_

#### F. MENINGITIS VACCINE (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)

Disease? Yes \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ if date unknown provide titer results and

Reactive (date): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ NonReactive (date): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Vaccine: Dose #1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

#### RECOMMENDED

#### H. HEPATITIS A

1. Immunization (Hepatitis A) Dose #1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

2. Immunization (Combined Hepatitis A and B)

Dose #1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose #3 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

#### I. HUMAN PAPILLOMAVIRUS VACCINE (HPV4)

Name of vaccine: \_\_\_\_\_

Dose #1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose #3 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

#### J. MENINGITIS B VACCINE (AGES 16-18)

Name of vaccine: \_\_\_\_\_

Dose #1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose #3 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Health Care Provider \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_