

# Physical Exam

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last Name First M D Y

Address \_\_\_\_\_  
Street City State Zip

The Julia Church Health Center of Hiram College requires that all students obtain a thorough physical examination prior to entering Hiram College. **This physical is required in addition to the Hiram College Sports Physicals.**

**PART II: TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.**

*All information must be in English.*

**Required:**

To the examining Health Care Provider:

Please review the student's immunization and health history and update as needed

Chronic Medical Conditions (include treatment and current status, attach additional comments or notes as appropriate):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Height:

Weight:

Blood Pressure:

Exam	Normal	Comments/ Follow Up	Exam	Normal	Comments/ Follow Up
Skin			Lungs		
Ears			Abdomen		
Eyes			Extremities		
Nose			Neurological		
Throat			Male: Genitalia		
Neck			Hernia		
Thyroid			Female: Breast		
Heart			Pelvic Exam (optional)		

**Immunization Records:**

**A. M.M.R. (MEASLES, MUMPS, RUBELLA)** (Two doses required )

1. Dose 1 given at age 12-15 months or later. .... #1 \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y

2. Dose 2 given at 4-6 yrs. and at least 28 days after first dose. .... #2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y

**B. POLIO**

1. Completed primary series of polio immunization: #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ #3 \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y M D Y M D Y

2. Type of vaccine: Live(OPV)\_\_\_\_\_ Inactivated (IPV)\_\_\_\_\_

**C. TETANUS-DIPHThERIA-PERTUSSIS**

Primary series with DTaP, DTP, DT, or Td, and booster with TD or Tdap in the last ten years. Health sciences students with patient contact should receive one dose of Tdap at an interval as short as 2 years since last Td as appropriate. Refer to ACIP for details.

1. Primary series of four doses with DTaP, DTP, DT, or Td:  
 #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ #3 \_\_\_\_/\_\_\_\_/\_\_\_\_ #4 \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y M D Y M D Y M D Y

2. Booster:  
 Tdap (preferred) . \_\_\_\_/\_\_\_\_/\_\_\_\_ **OR** Td \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y M D Y

## **Recommended but not required**

### **D. MENINGOCOCCAL**

Date    /   /     
M D Y

### **E. VARICELLA**

1. History of Disease Yes \_\_\_\_\_ No \_\_\_\_\_ Vaccinated #1    /   /    #2    /   /     
M D Y M D Y

### **F. HEPATITIS A**

1. Immunization (hepatitis A)

a. Dose #1    /   /    b. Dose #2    /   /     
M D Y M D Y

2. Immunization (Combined hepatitis A and B vaccine)

a. Dose #1    /   /    b. Dose #2    /   /    c. Dose #3    /   /     
M D Y M D Y M D Y

### **G. HEPATITIS B**

a. Dose #1    /   /    b. Dose #2    /   /    c. Dose #3    /   /     
M D Y M D Y M D Y

### **H. GARDASIL**

a. Dose #1    /   /    b. Dose #2    /   /    c. Dose #3    /   /     
M D Y M D Y M D Y

### **I. TUBERCULOSIS SCREENING**

1. Does the student have signs or symptoms of active tuberculosis disease? Yes \_\_\_\_\_ No \_\_\_\_\_

If No, proceed to 2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

2. History of BCG? Yes \_\_\_\_\_ No \_\_\_\_\_ Proceed to 3.

3. Is the student a member of a high-risk group or is the student entering the health professions? Yes \_\_\_\_\_ No \_\_\_\_\_

If No, stop. If Yes, place tuberculin skin test (Mantoux only: Inject 0.1 ml of purified protein derivative [PPD] tuberculin containing 5 tuberculin units [TU] intradermally into the volar [inner] surface of the forearm.) A history of BCG vaccination should not preclude testing of a member of a high-risk group.

4. Tuberculin Skin Test:

Date Given:    /   /    Date Read:    /   /     
M D Y M D Y

Result: \_\_\_\_\_ (Record actual mm of induration, transverse diameter; if no induration, write "0")

Interpretation (based on mm of induration as well as risk factors): positive \_\_\_\_\_ negative \_\_\_\_\_

5. Chest x-ray (required if tuberculin skin test is positive) result: normal \_\_\_\_\_ abnormal \_\_\_\_\_

Date of chest x-ray:    /   /     
M D Y

### **Health Care Provider**

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone(\_\_\_\_\_) \_\_\_\_\_

1 The American College Health Association has published guidelines on tuberculosis screening of college and university students. These guidelines are based on recommendations from the Centers for Disease Control and the American Thoracic Society. For more information, visit [www.acha.org](http://www.acha.org) or refer to the CDC's Core Curriculum on Tuberculosis available at state health departments or at the following website: [www.cdc.gov/nchstp/tb/pubs/corecurr/](http://www.cdc.gov/nchstp/tb/pubs/corecurr/).

2 Categories of high risk students include those students who have arrived within the past 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence.

Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand.

Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g., prednisone 15 mg/d for 1 month) or other immunosuppressive disorders.