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

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FIRST YEAR STUDENT PHYSICAL FORM

*****For Licensed Providers 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 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 of fitness facilities and classes, intramural, club or intercollegiate sports and able to meet the physical and emotional demands of college life including studying abroad? ☐ YES ☐ NO Limited Explain:_____

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 emotional condition?

☐ **NO** ☐ **YES Describe:**_____

Surgeries_____**Dietary Restrictions**_____

----------**REQUIRED FOR VARSITY ATHLETES ONLY**----------

Sickle Cell Screen: Test date_____ ☐ **Positive** ☐ **Negative**

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 Health Care Provider Signature:_____

Print Provider's Name_____**Phone**_____**Fax**_____

Office Address_____

IMMUNIZATIONS REQUIRED FOR ALL STUDENTS

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

NAME_____
LAST FIRST (what is listed on your insurance card/legal documents) Middle Initial

DATE OF BIRTH_____
MONTH/DAY/YEAR Social Security Number PHONE

REQUIRED by Maryland law for ALL college students living on campus. Students need to have booster before arriving to campus.

MENINGITIS A, C, Y, W (MENACTRA) Booster (Must have had dose within previous 5 years) Date _____/_____/_____

MMR (Measles, Mumps, Rubella)

Dose 1 – Immunized at 12 months or before 5 years _____/_____/_____

Dose 2 – Immunized at 4 years or later (at least 28 days after first does) _____/_____/_____

POLIO, please circle vaccine type: Oral Inactivated

Completed primary series of polio immunizations _____/_____/_____

Hepatitis B

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____

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

TETANUS-DIPTHERIA

Completed primary series of tetanus-diphtheria immunizations _____/_____/_____

Received tetanus-diphtheria booster **within the last 10 years** _____/_____/_____ or Tdap booster (recommended for ages 11-64 unless contraindicated) _____/_____/_____

VARICELLA (CHICKEN POX)

Disease? Yes_____Date:_____/_____/_____ if date unknown provide titer result Reactive (date): _____/_____/_____

Non-Reactive(date): _____/_____/_____ OR Vaccine: Dose #1 _____/_____/_____ Dose #2_____/_____/_____

FOR INTERNATIONAL STUDENTS ONLY

BCG vaccine received. No_____ Yes_____Date given_____/_____/_____

IMMUNIZATIONS STRONGLY RECOMMENDED FOR ALL STUDENT

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 _____/_____/_____ OR

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 (This is different than the one required by Maryland Law)

Name of Vaccine: _____

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____

Health Care Provider Signature_____**Date**_____

Address_____**Phone**_____