**A close up of a logo

Description automatically generatedDue date: Queen Anne Building**

**Fall – July 15th : Spring – January 1st 300 Washington Avenue**

**Chestertown, MD 21620**

**1st YEAR STUDENT PHYSICAL FORM health\_services@washcoll.edu**

**\*\*\*For Licensed Providers to Complete\*\*\* washcoll.studenthealthportal.com**

**PH: 410-778-7261 Fax: 410-810-7101**

**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\_\_\_\_\_\_\_\_ Visual Acuity: Recommended**

**Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ With Without Correction**

**Current Medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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** |  |  |

1. **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

1. **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.

1. **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**

1. **FOR INTERNATIONAL STUDENTS ONLY.**
2. BCG vaccine received. No\_\_\_\_\_\_\_\_\_ Yes\_\_\_\_\_\_\_\_\_Date given\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

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1. **TETANUS-DIPTHERIA**
2. Completed primary series of tetanus-diphtheria immunizations \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_
3. Received tetanus-diphtheria booster **within the last 10 years** \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ or Tdap booster (recommended for ages 11-64 unless contraindicated) \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_
4. **MMR (Measles, Mumps, Rubella)**
5. Dose 1 – Immunized at 12 months or before 5 years \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_
6. Dose 2 – Immunized at 4 years or later (at least 28 days after first does) \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_
7. **POLIO,** please circle vaccine type: Oral Inactivated
8. Completed primary series of polio immunizations \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_
9. **Hepatitis B**
10. Dose #1 \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Dose #2 \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Dose #3 \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

**OR** Surface antibody \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Result: Reactive \_\_\_\_\_\_\_\_Non-reactive\_\_\_\_\_\_\_\_\_

1. **MENINGITIS VACCINE “A, C, Y, W”** (Required by Maryland law for college students)
2. Name of vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_
3. Booster required if original dose given before 16. Date \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_
4. **VARICELLA (CHICKEN POX)**
5. 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**