

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 within 6 month prior to arriving on campus.*

Height Weight Blood Pressure Pulse Wisual Acuity: Recommended Allergies Glasses Glasses Contact Lenses Glasses Contact Lenses Right 20/ Left 20/ Both 20/ Clinical Evaluation Normal Record Abnormal Findings Appearance (Report Marfan Stigmata) Skin Blead, Ears, Eyes, Nose, Hearing Normal Record Abnormal Findings Nouth, Teeth & Gums Neck & Thyroid Lungs/ Chest Breasts Breasts Breasts Brearts Bleart (supine & standing) Abdomen Genitalia Back / Spine Extremities / Musculosketal Rextremities / Musculosketal Breartory of the standing of the standing of the studying abroad? YES NO – Limited Explain Sickle Cell Screen Required for all Varsity Athletes test date Positive Meanus 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 Strips Screen Required for any physical or emtional condition? NO YES - describe Dictary Restrictions No No Surgeries Dictary Restrictions No Surgeries Surgeries	Name		D	OOB	Current Gend	Current Gender Identity		
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Current Medications Glasses Contact Lenses	Allergies_				_ With	□ Withou	t Correction	
Right 20/ Left 20/ Both 20/				☐ Glasses ☐ Contact Lenses				
Clinical Evaluation	Current i				_			
Appearance (Report Marfan Stigmata) Skin					_ Right 20/	Left 20/	Both 20/	
Skin Head, Ears, Eyes, Nose, Hearing	Clinical l	Evaluation	Normal	Record Abnormal I	indings			
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Mouth, Teeth & Gums								
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Print Provider's Name Phone Fax	Health Car	e Provider Signatur	p.		D	ate•		
TIME TO THE THE THE	Print Prov	ider's Name	~	Phon	D	Fax		
Office Address	Office Add	lress		1 11011	· •			

TUBERCULOSIS SCREENING AND IMMUNIZATIONS INFORMATION

NAME								
DATE	LAST OF BIRTH	FIRST	MI					
	MONTH/DAY/YEAR ompleted and signed by a Health Care	SSN Provider (include month, day year, and translate TIONS REQUIRED FOR ALL STUDE						
Α.	FOR INTERNATIONAL STUDENTS ON 1. BCG vaccine received. NoYes_	NLY. Date given / /						
В.	TETANUS-DIPTHERIA	phtheria immunizations//						
	Received tetanus-diphtheria booster <u>wi</u> unless contraindicated)/	thin the last 10 years / or Tda /	p booster (recommended for ages 11-64					
C.	MMR (Measles, Mumps, Rubella) 1. Dose 1 – Immunized at 12 months or b	efore 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						
Е.	1. Completed primary series of polio imm Hepatitis B							
	1. Dose #1/Dose	#2/Dose #3/						
	OR Surface antibody/	/ Result: ReactiveNon-rea	active					
F.	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/						
	VARICELLA (CHICKEN POX) Disease? Yes Date: / /	if date unknown provide titer resultsReactive(date	ate):/					
	NonReactive(date)://							
	Vaccine: Dose #1/	Oose #2/						
		RECOMMENDED						
*COVID	VACCINE: COVID vaccine (1 dose): Type	Date						
COVID	vaccine (2-dose): Type Date #1	Date #2						
COVID	Booster Type: Date							
*HEPAT	TISA							
	Immunizations (Hepatitis A) Dose #1/ Immunizations (Combined Hepatitis A and B)							
	Dose #1/ Dose #2	//_Dose #3//						
**HUMA	N PAPILLOMAVIRUS VACCINE (HPV) Name of Vaccine:							
		// Dose #3/						
***MEN	Name of Vaccine:							
	Dose #1/ Dose #2							
Health	Care Provider Signature		Date					
Address		Phone						