



Program of Study _____

SUID # _____

PHYSICAL EXAMINATION

SEX: M ___ F ___

LAST NAME FIRST NAME MIDDLE BIRTH DATE

Blood Pressure _____ Pulse _____ Height _____ Weight _____ lbs.

REVIEW OF SYSTEMS: ___ Negative ___ Positive (explain) _____

The College of Health Sciences (CHS) requires that all students have evidence of a physical examination from a physician, physician’s assistant, or nurse practitioner verifying that the individual is able to meet physical and mental requirements – with or without accommodation – for both didactic and clinical components of their respective program. The physical examination must be completed and this form submitted before the first day of class and annually thereafter. The student affirms that by submitting this form he or she consents to the disclosure of the information contained herein to the program, school and college’s administrators, faculty and staff, as well as experiential site preceptors/coordinators as is necessary to ensure compliance with program requirements and affiliated site requirements.

Are there abnormalities in the following systems? Describe fully, including any assistive devices which may be required (e.g. hearing aids, eyeglasses, prosthetics, etc.).

	NO	YES	Comments
HEENT			
Respiratory			
Cardiovascular			
Gastrointestinal			
Musculoskeletal			
Neurologic			
Dermatologic			

ALLERGIES: _____

Is the patient now under treatment for any medical or psychological condition? NO ___ YES ___ (explain) _____

Does this patient have any active prescriptions, even if for occasional use only? NO ___ YES ___ (list) _____

Has this patient ever been diagnosed with alcoholism or another drug dependency (not including tobacco)? NO ___ YES ___ (list) _____

Are there any conditions, physical and /or psychological, which may interfere with functioning as a health professional student in the classroom or clinical setting? NO ___ YES ___ (please comment)

NOTES/COMMENTS _____

Healthcare Professional’s Name/Credentials: _____ DATE: _____

Address: _____ City: _____

State: _____ Zip: _____

Veterans: Your Discharge Physical is Acceptable

Log onto www.ebenefits.va.gov. Click “access my documents” under “Health Section” and download physical and immunization records.

REVIEWED BY _____
2.15.2016



IMMUNIZATION RECORD

Required of all students – Due one month prior to arrival/classes

Name: _____ SU ID: _____
Last First MI

Email address: _____ Date of Birth: ____/____/____

Phone number: (____)____-_____

Enrolling: Fall Jan Term Spring Summer of Year 20____ Program of Study: _____

Living in Campus Housing? Yes [] No []

TUBERCULOSIS SCREENING (student must answer BOTH screening questions)

1. Does the student have signs or symptoms of active tuberculosis disease? (symptoms include: persistent , coughing up blood, fever, fatigue, unexplained weight loss, etc.)

Yes [] No [] **If No, proceed to 2. If yes, proceed to #3** for additional evaluation to exclude active tuberculosis disease.

2. Is the student a member of a high risk group or is the student entering a health profession? Yes [] No [] **If No, stop. If yes, proceed to #3 below.**

-High risk students include those who have arrived within the past 5 years from any foreign country EXCEPT: Western Europe, Canada, Australia or New Zealand. Additional high-risk categories include those with HIV infection or other immunosuppressive disorders, h/o IV drug use, or those who have resided in, or worked in high-risk congregate settings such as prisons, shelters, hospitals, nursing homes, etc.

-Also includes students currently working in a healthcare setting or entering into the clinical portion of a health profession field of study; does not include pre-requisite courses

3. If the student answers 'yes' to either of the questions above, please proceed with the Tuberculosis screening:

a. PPD Skin Test (Mantoux): Must be within 6 months of entrance date.

Date Given: ____/____/____ Date Read: ____/____/____ Results: (mm induration) _____ **If positive, report to Health Department for further evaluation (chest x-ray and IGRA)**
month/day/year month/day/year

b. Healthcare workers/students require a **one-time** 2-step PPD Skin Test (must be at least 1 but no greater than 3 weeks after the first skin test)

Date Given: ____/____/____ Date Read: ____/____/____ Results: (mm induration) _____ **If positive, report to Health Department for further evaluation (chest x-ray and IGRA)**
month/day/year month/day/year

OR

c. IGRA (Quantiferon gold or T-spot) accepted in lieu of TB Skin test within 6 months of entrance **for students with history of positive TB Skin test.**

- Must provide copy of lab report, chest x-ray report of negative findings, and the Samford TB questionnaire. **Result** _____ **Date** _____

OR

d. Chest x-ray (required if student has history of latent or active TB disease*) -Date of Chest x-ray (must be within 6 months of entrance): _____

-Results: Normal [] Abnormal []

-Must attach documentation of treatment, chest x-ray report, and TB questionnaire.

VACCINATIONS REQUIRED OF ALL STUDENTS:

M.M.R. (Measles, Mumps and Rubella)

Born before 1957, no MMR immunization required

Combined Vaccines (Two doses; at least one month apart)

M.M.R (Measles,Mumps,Rubella)	#1 ____/____/____ month/ day/ year	#2 ____/____/____ month/day/yea r
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OR

Individually Administered Vaccines

Measles	#1 ____/____/____ month/day/year	#2 ____/____/____ month/day/year
Mumps	#1 ____/____/____ month/day/year	
Rubella	#1 ____/____/____ month/day/year	

OR

Laboratory Evidence of Immunity (all 3 required) in lieu of vaccines

*must submit copy of lab report

*if not immune, please complete the vaccination series

Measles	#1 ____/____/____ month/day/year	Result: Immune or Non-Immune
Mumps	#1 ____/____/____ month/day/year	Result: Immune or Non-Immune
Rubella	#1 ____/____/____ month/day/year	Result: Immune or Non-Immune



IMMUNIZATION RECORD

Required of all students – Due one month prior to arrival/classes

Tdap (TETANUS-DIPHTHERIA-ACELLULAR PERTUSSIS)

At least one dose required within the last 10 years	____/____/____ month/ day/ year
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VACCINATIONS REQUIRED OF STUDENTS LIVING ON CAMPUS:

VARICELLA (Chickenpox) ALSO REQUIRED FOR STUDENTS ENROLLED IN THE COLLEGE OF HEALTH SCIENCES

History of Disease	____/____/____ Month Day Year (Minimum Month/Year as date accepted) please provide laboratory evidence of immunity if date not available)	OR	Immunizations (Two doses required) #1 ____/____/____ Month Day Year	OR	#2 ____/____/____ Month Day Year	Laboratory Evidence of Immunity* ____/____/____ Month Day Year RESULT: <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune
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*must provide copy of lab report
*if not immune, please complete the vaccination series

MENINGOCOCCAL (quadrivalent - A,C,Y, W-135) (must have one dose since 16th birthday)

Immunization	____/____/____ Month Day Year
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RECOMMENDED VACCINATIONS:

HEPATITIS B - REQUIRED FOR STUDENTS ENROLLED IN THE COLLEGE OF HEALTH SCIENCES

Immunizations <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; padding: 5px;">#1 ____/____/____ Month Day Year</td> <td style="width: 33%; padding: 5px;">#2 (at least one month after dose #1) ____/____/____ Month Day Year</td> <td style="width: 33%; padding: 5px;">#3 (at least six months after dose #1 OR four months after dose #2) ____/____/____ Month Day Year</td> </tr> </table>	#1 ____/____/____ Month Day Year	#2 (at least one month after dose #1) ____/____/____ Month Day Year	#3 (at least six months after dose #1 OR four months after dose #2) ____/____/____ Month Day Year	OR	Laboratory Evidence of Immunity* <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; padding: 5px;"> Hepatitis B Surface Antibody (*must provide copy of lab report) ____/____/____ Month Day Year </td> <td style="width: 40%; padding: 5px;"> RESULT: <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune </td> </tr> </table>	Hepatitis B Surface Antibody (*must provide copy of lab report) ____/____/____ Month Day Year	RESULT: <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune
#1 ____/____/____ Month Day Year	#2 (at least one month after dose #1) ____/____/____ Month Day Year	#3 (at least six months after dose #1 OR four months after dose #2) ____/____/____ Month Day Year					
Hepatitis B Surface Antibody (*must provide copy of lab report) ____/____/____ Month Day Year	RESULT: <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune						

THIS SECTION TO BE FILLED OUT BY HEALTH CARE PROVIDER ONLY (within 6 months of entrance)

Student Health Information

Please list any potential communicable illnesses: _____

MD/PA/NP Signature: _____ Date: _____ within 6 months of entrance
 Print Name: _____ Phone: (____) _____ - _____
 Address: _____