Samford University
College of Health Sciences

PHYSICAL EXAMINATION

Program of Study _____

SUID # _____

_____ **SEX:** M ____ F ____

LAST NAME **FIRST NAME** **MIDDLE** **BIRTH DATE**

Blood Pressure _____ Pulse _____ Height _____ Weight _____ lbs. Vision _____right _____left

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.

REVIEW OF SYSTEMS:
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: _____

Address: _____

City: _____ State: _____ Zip: _____

SIGNATURE OF PROVIDER:_____ DATE:_____

***Veterans: Your Discharge Physical is Acceptable**

Samford University
College of Health Sciences

IMMUNIZATION RECORD

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

Name:_____ **SU ID:**__ __ __ __ __ __ __ __ __
Last *First* *MI*

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

Phone number: (____)_____-_____

Enrolling: ☐Fall ☐ Spring ☐ Summer of **Year** 20___ **Program of Study:** _____

Living in Campus Housing? Yes [ ] No [ ]

Immunization history must be completed and signed by a health care provider
OR
Upload original immunization records directly to ESS at www.Es2.com

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/year

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

Tdap (TETANUS-DIPHTHERIA-ACELLULAR PERTUSSIS)

At least one dose required within the last 10 years	____/_____/_____ month/ day/ year

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	#2 / / Month Day Year

OR

Laboratory Evidence of Immunity*
/ /
Month Day Year
RESULT:
[ ] Immune
[ ] Non-Immune

*must provide copy of lab report
*if not immune, please complete the vaccination series

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IMMUNIZATION RECORD

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LAST *FIRST* *MI*

VACCINATIONS REQUIRED

INFLUENZA (required between September and August)

Immunization	/ / Month Day Year

HEPATITIS B

Immunizations

#1	#2 (at least one month after dose #1)	#3 (at least six months after dose #1 OR four months after dose #2)
/ / Month Day Year	/ / Month Day Year	/ / Month Day Year

OR

Laboratory Evidence of Immunity*

Hepatitis B Surface Antibody *(*must provide copy of lab report)*	/ / Month Day Year	RESULT: [ ] Immune [ ] Non-Immune

VACCINATIONS REQUIRED OF ALL STUDENTS LIVING ON CAMPUS:

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

Immunization	/ / Month Day Year

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: _____

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IMMUNIZATION RECORD

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Patient _____
LAST *FIRST* *MI*

TUBERCULOSIS SCREENING:

The College of Health Sciences (CHS) at Samford University requires a two-step Tuberculosis (TB) screening two-step PPD skin test, a chest x-ray, or an IGRA blood test for all CHS students. If you have received BCG vaccine, an IGRA test is preferred. If you have a history of a positive TST (PPD) ≥10mm or IGRA please supply information regarding any evaluation and/or treatment below. **You only need to complete one section.** Guidelines are based upon the recommendation of the CDC and the American College Health Association.

The two-step TB test must be administered between one (1) and three (3) weeks apart.

Section A		**Date Placed**	**Date Read**	**Reading**
Negative Skin Test, Blood Test, or Chest X-ray	TST #1	_____/____/_____	_____/____/_____	_____ mm
	TST #2	_____/____/_____	_____/____/_____	_____ mm
	IGRA Blood Test □ T-spot □ Quantiferon Gold		□ Attach copy	
	Chest X-ray		□ Attach copy	
OR				
Section B		**Date Placed**	**Date Read**	**Reading**
History of Latent Tuberculosis, Positive Skin Test, or Positive Blood Test	Positive TST	_____/____/_____	_____/____/_____	_____ mm
	Positive IGRA Blood Test	**Date** _____/____/_____	**Type Test** □ T-spot □ Quantiferon Gold	□ Attach copy
	Chest X-ray	_____/____/_____	□ Attach copy	
	Prophylactic medications for latent TB taken?		□ Yes □ No	
	Total duration of prophylaxis?		_____ months	
	Date of last annual TB symptom questionnaire (if applicable)		_____/____/_____	
OR				
Section C				
History of Active Tuberculosis	Date of Diagnosis		_____/____/_____	□ Attach copy
	Date Treatment Completed		_____/____/_____	□ Attach copy
	Date of last annual TB symptom questionnaire (if applicable)		_____/____/_____	□ Attach copy
	Date of last Chest X-ray		_____/____/_____	□ Attach copy

MD/PA/NP Signature: _____ Date:_____ within 6 months of entrance

Print Name: _____ Phone: (_____) _____-_____

Address: _____

Immunization history must be completed and signed by a health care provider
OR
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