COLLEGE OF HEALTH SCIENCES
SAMFORD UNIVERSITY

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.ebenifits.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/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

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

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	#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

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

Immunization	/ / Month Day Year

RECOMMENDED VACCINATIONS:

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

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

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: _____

RETURN COMPLETED FORM TO:
COLLEGE OF HEALTH SCIENCES – UPLOAD vis ESS @ www.ES2.com