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[www.haverford.edu/healthservices](http://www.haverford.edu/healthservices)  
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## PHYSICAL EXAMINATION

### INSTRUCTIONS AND INFORMATION:

- The primary purpose of this form is to assure that immunizations are current and that entering student poses no public health problems; it also provides a means of identifying students with special health care needs and an historical basis for the provision of health care through the College Health Service.
- A Late fee of \$50.00 will be charged for failure to submit fully completed Health Forms by the required July 21 deadline.**
- Registration will be withheld until these forms are returned with documentation of required immunization.
- Information on this form is CONFIDENTIAL and solely for the Health Services and will not be released without the student's consent.

Student: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Last Name First Name Middle Initial mo. day yr.

Address: \_\_\_\_\_  
 Street Town State Zip

Student Cell PHONE# \_\_\_\_\_

To be completed by your Health Care Professional other than parent.

	Normal	Abnormal (describe)	Date: _____
1. Head, Ears, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Breasts	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Hernia	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Metabolic/Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Neuropsychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Pelvic Examination (if indicated)	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Rectal Examination (if indicated)	<input type="checkbox"/>	<input type="checkbox"/>	_____

To Provider: check ACHA or CDC website for full list of high risk group.

a. does the student have signs or symptoms of active Tuberculosis diseases yes\_\_ no\_\_

b. Is student a member of a high risk group or is the student entering the health profession yes\_\_ no\_\_

If Yes to either question place a PPD if No then stop

c. Please note – required PPD test must be done within 6 months of arrival to school.

Measurements

Height: \_\_\_\_ft. \_\_\_\_ in.

Weights: \_\_\_\_\_lbs.

Blood Pressure:

\_\_\_\_/\_\_\_\_MM/HG

Month Year

\_\_\_\_ Tuberculin PPD Results: \_\_ Positive \_\_ Negative or \_\_BCG Vaccine Administered

\_\_\_\_ Chest X-Ray required only if Tuberculin Skin Test is positive  
 Results: \_\_Positive \_\_Negative

Other laboratory test per health care provider's discretion.

(over)

**IMMUNIZATIONS**

**A CURRENT IMMUNIZATION HISTORY MUST BE FURNISHED BY ALL HAVERFORD STUDENTS.**

1. Tetanus/Diphtheria – Completed primary series:  
Month\_\_\_\_\_ Year\_\_\_\_\_

Tetanus/Diphtheria Booster  
Within the last 10 years **required**  
Month\_\_\_\_\_ Year\_\_\_\_\_

Tdap Month\_\_\_\_\_ Year\_\_\_\_\_

2. Polio – Completed primary series **required**  
Month\_\_\_\_\_ Year\_\_\_\_\_  
Type of vaccine \_\_\_OPV and/or \_\_\_IPV

3. MMR **2 dose requirement**  
Month\_\_\_\_\_ Year\_\_\_\_\_ (1<sup>st</sup> dose) \_\_\_\_\_Month\_\_\_\_\_Year(2<sup>n</sup>dose)  
Month\_\_\_\_\_ Year\_\_\_\_\_ (3<sup>rd</sup> dose if applicable)

4. Mumps  
Immunization recommended if no history of illness  
Month\_\_\_\_\_ Year\_\_\_\_\_

5. Measles (Rubeola)  
Either certification of immunization, or proof of  
Positive titer is required. History of illness is  
not sufficient.  
Month\_\_\_\_\_ Year\_\_\_\_\_ immunization  
Or  
Month\_\_\_\_\_ Year\_\_\_\_\_ Protective Titer\_\_\_\_\_  
Copy of lab reports must be attached (results)

6. Rubella  
Either certification of immunization after 15 months of age or  
proof of positive titer is required. History of illness is not sufficient.  
Month\_\_\_\_\_ Year\_\_\_\_\_ immunization  
or  
Month\_\_\_\_\_ Year\_\_\_\_\_ protective titer\_\_\_\_\_  
Copy of lab report must be attached (results)

7. Hepatitis B Series **required**  
Month\_\_\_\_\_ Year\_\_\_\_\_ (1<sup>nd</sup> dose)  
Month\_\_\_\_\_ Year\_\_\_\_\_ (2<sup>nd</sup> dose)  
Month\_\_\_\_\_ Year\_\_\_\_\_ (3<sup>rd</sup> dose)

8. Hepatitis A Series Recommended  
Month\_\_\_\_\_ Year\_\_\_\_\_ (1<sup>nd</sup> dose)  
Month\_\_\_\_\_ Year\_\_\_\_\_ (2<sup>nd</sup> dose)

9. Varicella Vaccine Recommended if no history of illness  
Month\_\_\_\_\_ Year\_\_\_\_\_ (1<sup>st</sup> dose) Varicella antibody  
Month\_\_\_\_\_ Year\_\_\_\_\_ (2<sup>nd</sup> dose) Reactive \_\_\_ Non-Reactive \_\_\_  
Date of Disease or Illness Month\_\_\_\_\_ Year\_\_\_\_\_

10. Pre-Exposure vaccination against Meningococcal Meningitis  
A, C, Y and W-135 **required**  
Month\_\_\_\_\_ Year\_\_\_\_\_

**Female Students:**  
Gardasil (HPV Vaccine)  
\_\_\_\_Month\_\_\_\_\_ Year(1<sup>st</sup> dose) \_\_\_\_\_Month\_\_\_\_\_ Year(2<sup>nd</sup> dose)  
\_\_\_\_Month\_\_\_\_\_ Year(3<sup>rd</sup> dose)

**MEDICAL EXEMPTION**

YES \_\_\_\_\_ NO \_\_\_\_\_  
**Exemption letter must be attached from Health Provider**

**RELEGIOS EXEMPTION**

YES \_\_\_\_\_ NO \_\_\_\_\_  
**Exemption letter must be attached from Clergy member.**

How long have you known this student? \_\_\_\_\_

Is there any reason why this student should not engage in physical activities including specifically, physical education courses and athletics? \_\_\_\_\_NO \_\_\_\_\_YES  
If yes, please explain indicated restrictions, their basis and probable duration.

Does this student have any disability? \_\_\_\_\_NO \_\_\_\_\_YES, Explain \_\_\_\_\_  
If yes, you may need to provide further documentation.

Does this student require special accommodations for disability? \_\_\_\_\_NO \_\_\_\_\_YES, Explain \_\_\_\_\_

Is this individual under care for a chronic condition or serious illness? \_\_\_\_\_NO \_\_\_\_\_YES, Explain \_\_\_\_\_  
**If yes, Health Care Provider should send clinical reports so we may provide continuity of care.**

Please list individual medication?  
Medication \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_  
Medication \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_  
Medication \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Any recommendation for special dietary requirements? \_\_\_\_\_NO \_\_\_\_\_YES, Explain \_\_\_\_\_

Any recommendation for special housing consideration? \_\_\_\_\_NO \_\_\_\_\_YES, Explain \_\_\_\_\_

Please list any additional information you feel is necessary. \_\_\_\_\_

Name of Health Care Provider (please print) \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

Signature of Health Care Provider \_\_\_\_\_ Date \_\_\_\_\_