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Ambulatory Health Care, Inc.



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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"/>	_____

If Abnormal: Please enclose letter with diagnoses, treatment, medications, labs, x-ray reports and test.

www.cdc.gov www.acha.org

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_____ (1st dose) _____Month_____Year(2ⁿdose)

Month_____ Year_____ (3rd 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_____ (1nd dose)

Month_____ Year_____ (2nd dose)

Month_____ Year_____ (3rd dose)

8. Hepatitis A Series Recommended

Month_____ Year_____ (1nd dose)

Month_____ Year_____ (2nd dose)

9. Varicella Vaccine Recommended if no history of illness

Month_____Year_____ (1st dose) Varicella antibody

Month_____Year_____ (2nd 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(1st dose) _____Month_____Year(2nd dose)

_____Month_____Year(3rd dose)

MEDICAL EXEMPTION

YES ___ NO ___

Exemption letter must be attached from Health Provider

RELEGIIOUS 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_____