Questions or Comments?

Ph: 610-896-1089
Fax: 833-846-6925
Email: hc-healthservices@haverford.edu

HAVERFORD COLLEGE
HEALTH SERVICES

Deadline for Submission:

August 1, 2023

PHYSICAL EXAMINATION

Academic Year 2023-2024

- ☐ Information on this form is confidential and solely for the Health Services. PE form will not be released without the student's consent.
- ☐ Form must be uploaded to the HaverHealth Portal or faxed to 833-846-6925 by August 1.
- ☐ Late fee of $75.00 will be charged for failure to complete Matriculation Requirements detailed on Health Services website by August 1.
- ☐ Exam must be completed after August 2, 2022 by a Health Care Professional unless student is NCAA (Sports Physical after February 1).
- ☐ This form can only be completed by a healthcare professional, *not a student or parent*.

Student's Legal Name:	Date of Birth:
Date of Physical Exam:	Student ID:
Sex assigned at birth (M, F, Intersex):	If applicable: ☐ MTF ☐ FTM

GENERAL MEDICAL INFORMATION

	Normal	**Abnormal**	**Defer**	*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
Height: ( ) inches				
Weight: ( ) pounds				
Heart Rate: ( )				
Pulse Ox: ( )				
Blood Pressure: (/)				
Skin				
Eyes/Visual Acuity ☐ Corrected				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Psychiatric Currently under psychiatric care? ☐ **Yes*** ☐ No Psychiatric (Continued) Please check if applicable: ☐ Addiction ☐ **ADHD**** ☐ **Anxiety**** ☐ **Depression**** ☐ Eating Disorder ☐ Other:				*If yes, please provide office information below including phone and fax number. Include any psychiatric prescription renewal information. **Name: _____ **Phone: _____Fax: _____ **Please be aware that Health Services cannot initiate, adjust, or renew psychiatric medications. **Contact your PCP or psychiatrist now to initiate your mental health prescription **renewals**.
Other				

MEDICATIONS – ATTACHED ADD'L DOCUMENTATION IF REQUIRED			
Medication Name	Dose	Instructions	Indication

PATIENT NAME: _____

DOB: _____

ALLERGIES			
☐ Medication	☐ Environmental	☐ Food	☐ Stinging Insects
Does the student require an Epi Pen? ☐ Yes ☐ No			

HOSPITALIZATIONS OR SURGERY	
Date	Reason
Date	Reason

PHYSICAL ACTIVITY CLEARANCE		
Can patient engage in physical education, club or varsity sports without restriction?	☐Yes	☐ No
If no, please specify recommendations for physical activity:		

ACCESS AND DISABILITY SERVICES https://www.haverford.edu/access-and-disability-services

Students requesting any kind of accommodation due to a disability **must provide documentation** of a condition that has a current functional impact and meets the current legal definition of a disability.

For students who have food allergies and other food-related needs, ADS works collaboratively with the student, dietician and the dining services management and staff to create a plan that best meets their dietary needs within the institutional setting. Please contact: **Natalie Zaparzynski, MA, RD, LDN** *Bi-Co Dietitian* nzaparzyns@brynmawr.edu (610) 526-7417 for more information.

MEDICAL CLEARANCE REQUIREMENTS FOR PARTICIPATION IN VARSITY ATHLETES

Sickle Cell Requirement

This is an NCAA requirement that Haverford College requires from all of its varsity athletes. Upload a blood test confirming your Sickle Cell status into your HaverHealth Portal by August 1, 2022 and use the tag "Sickle Cell Lab Results" For students born in the United States, in many cases this testing has been done at birth and results should be available via the birth hospital or pediatrician. You can use this link to find the information from the CDC specific to the state of your birth, whether you were screened, and the forms to request that result. If you would like, you can have that test result faxed to: Curt Mauger Head Athletic Trainer Haverford College 833-570-8643 (fax)

For incoming students who were born abroad, who cannot obtain previous testing, or who cannot arrange to be tested prior to their arrival on campus, testing for Sickle Cell Trait can be arranged through Haverford's Health Services.

IMMUNIZATION RECORD

Definition of Vaccinated

For the purposes of these policies, a "vaccinated" Haverford employee or student means that the individual has provided documentation to the College that, no later than two weeks of becoming eligible, they have received a booster dose (Pfizer or Moderna) following an FDA-authorized (Pfizer, Moderna, or Johnson & Johnson) COVID-19 vaccine. The College will also accept a different WHO-approved vaccine as satisfying the initial vaccine requirement, with the accompanying strong recommendation from the College and its medical advisors that such vaccinated individuals also gain an FDA-authorized vaccine. All Haverford faculty, staff, and students are required to be vaccinated with boosters or to receive a medical or religious exemption per the COVID-19 Vaccine Policy.

For more information regarding Haverford College's vaccination requirement for students, please visit https://docs.google.com/document/d/1pNj9auftISYFc4kqDTx6pG55QLHBUm2IycqlG8fIY8E/edit.

IMMUNIZATION EXEMPTION(S): DECISION NOT TO VACCINATE: https://www.haverford.edu/sites/default/files/Office/Health-Services/Decision-not-to-Vaccinate.pdf			
☐ Medical	Date Issued:	Reason:	Date Rescinded:
☐ Religious	Date Issued:	Reason:	Date Rescinded:

Haverford College follows the American College Health Association (ACHA), the Pennsylvania State Mandatory Vaccination Code, the Advisory College of Immunization Practices (ACIP) and the CDC's recommendations for immunization compliance guidelines. For the safety of all students, faculty and staff, immunizations are **mandatory**.[1] Students may be exempted from the immunization requirements if there is a medical contraindication or if the student's religious or philosophical belief prohibits immunizations.

Per Pennsylvania State law for schools:

(a) Medical exemption. Children need not be immunized if a physician or the physician's designee provides a **written statement** that immunization may be detrimental to the health of the child. When the physician determines that immunization is no longer detrimental to the health of the child, the child shall be immunized according to this subchapter.

(b) Religious exemption. Children need not be immunized if the parent, guardian or emancipated child objects **in writing** to the immunization on religious grounds.

For more information regarding Pennsylvania's vaccination requirements for students, please visit the following resources: Pennsylvania Department of Health: School Immunizations; 28 Pa. Code § 23.84: Exemption from immunization.

IMMUNIZATION RECORD

PATIENT NAME: _____

DOB: _____

ALL DOCUMENTATION MUST BE IN ENGLISH

REQUIRED:

1. MEASLES (RUBEOLA), MUMPS AND RUBELLA (GERMAN MEASLES)
   Dose #1 _____/_____/_____ Dose #2 _____/_____/_____
   OR
   MMR Titer *must attach laboratory results Date of Titer: _____/_____/_____ Result: _____

2. MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135) (MCV) ***1 Dose required after 16 years of age.***
   Dose #1 _____/_____/_____ Dose #2 _____/_____/_____

3. SEROGROUP B MENINGOCOCCAL **– One (1) required before arrival to campus.**
   MenB-RC (Bexsero) Dose #1 _____/_____/_____ Dose #2 _____/_____/_____
   MenB-FHbp (Trumenba) Dose #1 _____/_____/_____ Dose #2 _____/_____/_____

4. TETANUS, DIPHTHERIA, PERTUSSIS
   Primary series completed? Yes ____ No ____ Date of most recent TDap: _____/_____/_____

5. COVID-19 Bivalent **– One (1) required bivalent dose *after* 9/1/2022.**
   Bivalent: _____/_____/_____ ☐ Pfizer ☐ Moderna

6. HEPATITIS B
   Immunization (hepatitis B)
   Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____
   Immunization (Combined hepatitis A and B vaccine)
   Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____
   OR
   HEPATITS B Titer *must attach laboratory results Date of Titer: _____/_____/_____ Result: _____

7. VARICELLA
   Dose #1 _____/_____/_____ Dose #2 _____/_____/_____
   OR
   Varicella Titer *must attach laboratory results Date of Titer: _____/_____/_____ Result: _____
   OR
   Date of Disease: _____/_____/_____

8. POLIOMYELITIS (POLIO) – Completed Primary Series
   Primary series completed? Yes ____ No ____ Date of most recent OPV/ IPV Dose: _____/_____/_____

RECOMMENDED IMMUNIZATIONS:

1. COVID-19 Primary Monovalent Series
   Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____
   ☐ Pfizer ☐ Moderna ☐ Other: _____

2. HEPATITIS A
   Dose #1 _____/_____/_____ Dose #2 _____/_____/_____
   OR
   (Combined hepatitis A and B vaccine) Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____

3. PNEUMOCOCCAL VACCINES
   PCV 13 _____ Date _____/_____/_____
   PPSV 23 _____ Date _____/_____/_____

4. HUMAN PAPILLOMAVIRUS VACCINE
   Immunization (indicate which preparation, if known) 9-valent (HPV9) _____ or other _____
   Dose #1 _____/_____/_____ Dose #2 _____/_____/_____Dose #3 _____/_____/_____

PATIENT NAME: _____

DOB: _____

TUBERCULOSIS RISK ASSESSMENT (TBRA)

SECTION 4: TO BE COMPLETED BY HEALTH CARE PROVIDER

Have you ever had a positive tuberculosis (TB) test?	☐ Yes *If you have had a positive TB test in the past, you must submit documentation of the positive test, including chest x-ray report and treatment records. Further testing may not be required.*	☐ No
Do you have any of the following signs or symptoms of active TB disease?	Check all that apply ☐ Unexplained fever/chills for more than 1 week ☐ Persistent cough of unknown etiology for more than 3 weeks ☐ Cough with bloody sputum ☐ Night sweats ☐ Unexplained weight loss or Unexplained fatigue	☐ No
Do any of the following situations apply to you?	Check all that apply ☐ Close contact with a person known or suspected to have TB ☐ Use of any illegal injectable drugs ☐ At risk for Human Immunodeficiency Virus (HIV) infection ☐ Volunteered, resided, or worked in a healthcare facility or congregate living setting (homeless shelter, nursing home, or correctional facility) for longer than one (1) month ☐ History of silicosis, diabetes, renal disease, blood disorders or cancer ☐ History of gastrectomy, jejunoilieal bypass, or chronic malabsorptive condition ☐ History of a solid organ transplant (kidney, heart, liver) ☐ Immunosuppressive therapy, such as prolonged corticosteroid therapy, chemotherapy or TNF-antagonist medications (Humira, Embrel, Remicade) ☐ Are less than 10% of normal body weight or malnourished	☐ No
Within the past 5 years, have you traveled to or living in any of the following areas for more than one month?	Check all that apply ☐ Africa ☐ Asia ☐ Central America ☐ Cuba ☐ Dominican Republic ☐ Eastern Europe ☐ Haiti ☐ India and other Indian subcontinent nations ☐ Middle East (except Egypt, Saudi Arabia, Jordan, Lebanon, UAE) ☐ Portugal ☐ South America ☐ South Pacific (except Australia and New Zealand)	☐ No

If you checked any boxes in column two, TB testing is required. American Academy of Pediatrics (AAP) recommends a TB blood test (interferon-gamma release assay [IGRA]).

QuantiFERON-TB Gold Plus	T-SPOT®.*TB*
Date of Test:	Date of Test:
Result:	Result:

Chest X-Ray **required** only if Tuberculin Skin Test or IGRAs **positive.** Date of X-Ray _____ Results: ___Negative ___Positive
(**If positive, attach Chest X-RAY report and treatment.)** If free of active disease, consider treatment for latent TB illness**.**

https://www.health.pa.gov/topics/Documents/Diseases%20and%20Conditions/TB/ADULT%20Final_pa-tb-risk-assessment.pdf

Provider Name (Print Clearly):	
Provider Signature:	
Assessment Date:	
Practice Name/ Practice Stamp:	
Address:	
Phone:	
Fax:	

This completed exam form can be faxed to 833-846-6925. 3/23