Questions or Comments?

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Fax: 833-846-6925
Email: hc-healthservices@haverford.edu

HAVERFORD COLLEGE
HEALTH SERVICES

Deadline for Submission:

August 1, 2024

PHYSICAL EXAMINATION

Academic Year 2024-2025

- ☐ 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, 2024.
- ☐ Late fee of $75.00 will be charged for failure to complete Matriculation Requirements detailed on Health Services website by August 1, 2024.
- ☐ Exam must be completed after August 2, 2023 by a Health Care Professional unless student is a Varsity Athlete (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

PHYSICAL EXAM FINDINGS

	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 pertinent information:				

PATIENT NAME: _____

DOB: _____

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

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

PAST MEDICAL HISTORY

SPECIALTY CARE PROVIDERS			
Provider Name	Condition Managed	Phone Number	Fax Number

HOSPITALIZATIONS OR SURGERY	
Date	Reason
Date	Reason

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

IMMUNIZATION RECORD

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 more information regarding Haverford College's vaccination requirement for students, please visit
https://www.haverford.edu/be-safe
https://www.haverford.edu/health-services/immunization-policy

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:

PATIENT NAME: _____

DOB: _____

IMMUNIZATION RECORD

(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 _____/_____/_____

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

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

3. 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) ***REQUIRED***

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 "YES" in column two, TB testing is required. American Academy of Pediatrics (AAP) recommends a TB blood test (interferon-gamma release assay [IGRA]). Skin testing is <u>not</u> accepted (TST).

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

Chest X-Ray **required** only if IGRA is **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:	

03/23, 11/23, 2/24