CHRISTENDOM COLLEGE

Semester Enrolling:
☐ Fall
_____(year)
☐ Spring
_____(year)

HEALTH AND PHYSICAL EXAM FORM

This form is a requirement for enrolling as a student at Christendom College and will be kept confidential. **Pages one and two should be filled out by the student. Pages three and four are to be filled out by your health care provider at the time of your physical exam.** The student is responsible for updating this form. Students will NOT **be permitted to register for classes** if the *Health and Physical Exam Form* is not completed. Questions about this form can be directed to the Nurse's Office or the Student Life Office of Christendom College.

Last Name | **First Name** | **Middle Initial**

Date of Birth (Month, Date, & Year) | ☐ **Male** ☐ **Female** **Gender**

Permanent Address | **City or Town** | **State** | **Zip Code**

Home Phone | **Student Cell Phone**

Emergency Contact Information

Emergency Contact-name and relationship | Home Phone | Cell Phone | Work Phone

Emergency Contact Address | City | State | Zip | E-mail Address

Parent/Guardian Notification: I authorize the staff of Christendom College to notify a parent/guardian in the event of an emergency/serious illness. _____ (

Personal Physician

Primary Physician | Address | Phone

Family History: Have any of your relatives ever had any of the following?

	Yes	No	Relationship		Yes	No	Relationship
Arthritis				Epilepsy, Seizures			
Asthma, Hay Fever				High Blood Pressure			
Cancer				Kidney Disease			
Diabetes				Mental Illness			
Death Before Age 50				Tuberculosis			
Disability Due to Heart Disease				Other (specify)			

MEDICAL HISTORY Student to Complete and Sign.

Alcohol Abuse	□Yes □No	Fainting/Dizziness	□Yes □No	Polio	□Yes □No
Anemia	□Yes □No	Gallbladder Trouble	□Yes □No	Psychological Counseling	□Yes □No
Arthritis	□Yes □No	Hay Fever (Recurrent)	□Yes □No	Rheumatic Fever	□Yes □No
Asthma	□Yes □No	Head Injury/Concussion	□Yes □No	Rubella	□Yes □No
Back Problems	□Yes □No	Headache (Recurrent)	□Yes □No	Scarlet Fever	□Yes □No
Bone Fractures	□Yes □No	Heart Disease/Problems	□Yes □No	Sickle Cell Trait (Anemia)	□Yes □No
Cancer	□Yes □No	Hepatitis/Jaundice	□Yes □No	Sinus Trouble	□Yes □No
Chicken Pox	□Yes □No	Hernia/Rupture	□Yes □No	Skin Problems (Chronic)	□Yes □No
Colitis	□Yes □No	High Blood Pressure	□Yes □No	Sleep Problems	□Yes □No
Convulsions/Seizures	□Yes □No	Intestinal/Stomach Trouble	□Yes □No	Smoking (how long?)	□Yes □No
Cough (Chronic)	□Yes □No	Joint Disease/Injury	□Yes □No	Spleen, Surgical Removal	□Yes □No
Depression/Anxiety	□Yes □No	Measles	□Yes □No	Thyroid Disease	□Yes □No
Diabetes	□Yes □No	Menstrual Problems	□Yes □No	Tuberculosis	□Yes □No
Disability/Handicap	□Yes □No	Migraine Headaches	□Yes □No	Urinary Tract Infection	□Yes □No
Drug Abuse	□Yes □No	Mononucleosis, Infectious	□Yes □No		
Ear/Hearing Trouble	□Yes □No	Mumps	□Yes □No		
Eating Disorder	□Yes □No	Paralysis	□Yes □No		
Eye Disease/Problems	□Yes □No	Pneumonia	□Yes □No		

Brief explanation of any marked

MEDICATIONS (list all currently taking)

ALLERGIES (Drug, Latex, Tape, Food, Others, etc.)

HOSPITALIZATIONS/SURGERIES (**If yes, please list date and reason**)

Carry an Epipen? □Yes □No

Medical Consent and Health Form Agreement

I give permission for treatment that may include, but is not limited to, routine, urgent, and emergency care, medicines, immunizations, laboratory tests, diagnostic studies, referral to hospitals, clinics or medical specialists deemed necessary by health care providers when the undersigned is not able to make such decisions or when emergency contact person(s) cannot be reached. It is understood and agreed that the Christendom College may release any medical information necessary to other physicians, insurance companies, and government agencies that may require such information. Christendom College is not responsible for any medical treatment received outside the Nurse's office.

Christendom College will make reasonable accommodations for health conditions; the ability/decision to make such accommodations is left solely to the discretion of the administration of Christendom College. I understand that the College may not grant some accommodations. I acknowledge and understand that Christendom College reserves the right to revise a student's standing considering his health condition.

I verify that all medical and psychological information I provide is complete and accurate. I understand that I am required to notify the Nurse's Office of Christendom College of any changes in my health that may occur while a current student. I understand I am personally responsible for seeking health care and informing the proper persons of any and all health conditions I have. I further agree and understand that any information that is withheld or any failure to inform the College of any physical health or mental health conditions/changes could result in disciplinary action including the possibility of permanent dismissal from the College.

_____ _____

Signature of Student **Date**

_____ _____

Signature of Parent/Guardian *(If the Student is under 18 years of Age)* **Date**

Physical Exam Form

To be completed by a licensed physician, physician's assistant, or nurse practitioner.

Last Name	First Name	Middle Initial

Month	Date	Year	☐ Male ☐ Female
Date of Birth			Gender

Height:_____ **Weight:**_____ **Blood Pressure:**_____ **Pulse:**_____

Clinical Evaluation	Normal	Abnormal	Comments
Skin			
Head, Ears, Eyes, Nose, Throat, Hearing, Visual Activity			
Tonsils, Teeth, Gums			
Neck & Thyroid			
Respiratory			
Breasts			
Cardiovascular			
Gastrointestinal			
Menstrual Cycle/Testes			
Back/Spine			
Extremities/Musculoskeletal/Femoral Pulses			
Neurologic			
Emotional/Psychological			
Other Findings			

Is there loss of or seriously impaired function of any paired organ? ☐ No ☐ Yes If yes, please explain:

_____

_____

Please explain any other physical conditions found during examination:

_____

_____

Is this student cleared for full physical activity, including participation in intramural, club, and intercollegiate sports and able to meet the physical and emotional demands of college life, including study abroad?

☐ Yes/Unlimited activity and fit for college. ☐ No/Limited Activity Reason:_____

Recommendation:_____

I have reviewed the medical history and examined the student noted above. The information is accurate and complete to the best of my knowledge.

Signature of Licensed Physician, PA, or NP **Date**

Print Name of Licensed Physician, PA, or NP **Date**

Review done by:
initials_____ **Date**_____

Missing Information Notification:
☐ **Letter** ☐ **Email** ☐ **Phone** ☐ **In-Person** **Initials**_____
Date___

IMMUNIZATIONS

To be completed by a licensed physician, physician's assistant, or nurse practitioner.

Effective Fall 2014:

1) All **international** students must have a Tuberculin Skin Test (Mantoux) done within 6 months prior to the start of the student's first semester. This can be recorded on the TB Screening section below or submitted separately, written in English.
2) The below immunizations are required for admission to Christendom College. This is to be completed by the start of the student's first semester or a plan for completing these immunizations need to be submitted. An immunization waiver for medical or personal exemption is located online

_____	Month _____	Day _____	Year _____
Student Name	**Date of Birth**		

TB Screening:

1. **Does the student have signs or symptoms of active TB disease ___Yes ___ No. If NO, proceed to question two.**
2. **Is the student a member of a high risk group, or an international student ___Yes ___No**

If NO, STOP. No further evaluation is needed at this time. If **YES**, place tuberculin skin test (Mantoux only). A history of BCG vaccination does not preclude testing of a member of a high risk group. History of BCG vaccine ___Yes ___No

3. Tuberculin Skin Test: (Mantoux) Must be within six months Date given __/___/__ Date read: __/__/__
Result:____ (record actual mm of induration, transverse diameter; if no induration, write "0")
Interpretation (based on mm of induration as well as risk factors): ___positive ___negative
4. Chest xray (required if tuberculin skin test is positive) __normal __abnormal__date of chest xray __/__/__
5. Treatment plan if indicated:_____

REQUIRED VACCINATIONS:

MMR If born after 12/31/56 two doses required. (Measles, Mumps, Rubella)	Dose #1 must be given on or after first birthday. Dose #2 must be given after 15 months of age and at least 28 days after 1st dose.	Dose #1 ___/_____/___ M D Y	Dose #2 ___/_____/___ M D Y	
Measles	If born after 12/31/56 two doses of live measles vaccine are required **or** positive serology.	Dose #1 ___/_____/___ M D Y	Dose #2 ___/_____/___ M D Y	Serology date ___/_____/___ M D Y ☐ Immune
Mumps	If born after 12/31/56 one dose of live mumps vaccine is required **or** positive serology.	Dose #1 ___/_____/___ M D Y		Serology date ___/_____/___ M D Y ☐ Immune
Rubella	If born after 12/31/56 one dose of live rubella vaccine is required **or** positive serology.	Dose #1 ___/_____/___ M D Y		Serology date ___/_____/___ M D Y ☐ Immune
Tetanus, Diphtheria, Pertussis	Dose within 10 years. Please specify: Td | Tdap	___/_____/___ M D Y		
Polio Vaccine	Date Series Completed	___/_____/___ M D Y		

RECOMMENDED VACCINATIONS:

Meningococcal Vaccine	One dose of either: ☐ Menomune™ ☐ Menactra™	___/_____/___ M D Y			
Varicella Vaccine	Two doses, disease date or serology results.	Dose #1 ___/_____/___ M D Y	Dose #2 ___/_____/___ M D Y	Serology date ___/_____/___ M D Y ☐ Immune	Disease Date ___/_____/___ M D Y

I verify that the immunization records and TB Screen results are complete and accurate to the best of my knowledge.

_____	_____	_____
Signature of MD, PA, or NP	**Phone Number**	**Date**