Due Date:
Fall – July 15th
Spring – January 1st

Washington College

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FIRST YEAR STUDENT PHYSICAL FORM

*****For Licensed Providers to Complete*****

TO THE EXAMINING HEALTH CARE PROVIDER: Please review the student's history and complete this report. Please comment on all positive answers. *This student has been accepted.* The information supplied will not affect his/her status. It will be used as a background for providing continued physical and mental health care on campus.

Physical Exam must be done witihin 6 month prior to arriving on campus.

Name____________________________________ **DOB**_________________ **Current Gender Identity**______________

Height________ **Weight**________ **Blood Pressure**________ **Pulse**________

Allergies____

Current Medications____

Visual Acuity: Recommended
☐ **With** ☐ **Without Correction**
☐ **Glasses** ☐ **Contact Lenses**
Right 20/ **Left 20/** **Both 20/**

Clinical Evaluation	Normal	Record Abnormal Findings
Appearance (Report Marfan Stigmata)		
Skin		
Head, Ears, Eyes, Nose,Hearing		
Mouth, Teeth & Gums		
Neck & Thyroid		
Lungs/ Chest		
Breasts		
Heart (supine & standing)		
Abdomen		
Genitalia		
Back / Spine		
Extremities / Musculosketal		
Neurologic		
Emotional / Psychological		

A. **Is this student cleared for physical activity <u>including</u> use of fitness facilities and classes, intramural, club or intercollegiate sports <u>and</u> able to meet the physical and emotional demands of college life including studying abroad?** ☐ **YES** ☐ **NO – Limited Explain**__________________________________

Sickle Cell Screen Required *only* for Varsity Athletes. **Test date**______________ ☐ **Positive** ☐ **Negative**

B. **Tuberculosis (TB) Screen Required for all Students- Any signs or symptoms of active TB disease?**
☐ **NO** – Is this student a member of a high risk group or an International student from a high risk country as defined by the CDC?
☐ **YES** --Proceed with additional evaluation to exclude active TB disease including PPD testing, IGRA, CXR and sputum evaluation as indicated, copies of results must be attached.

C. **Is this student under care (by any provider) for any physical or emotional condition?**
☐ **NO**
☐ **YES** – describe____

Surgeries_____________________________________ **Dietary Restrictions**________________________

I have reviewed the medical history, immunizations, conducted the TB screen and examined this student. The information on this form is accurate, full and complete to the best of my knowledge.

Health Care Provider Signature____ **Date:**____________________
Print Provider's Name____________________________________ **Phone**_______________ **Fax**__________________
Office Address____

IMMUNIZATIONS INFORMATION

NAME____

LAST FIRST MI

DATE OF BIRTH____

MONTH/DAY/YEAR SSN PHONE

To be completed and signed by a Health Care Provider (include month, day year, and translate all lab work and results in English)

FOR INTERNATIONAL STUDENTS ONLY.

BCG vaccine received. No_________ Yes_________Date given______/______/______

IMMUNIZATIONS REQUIRED FOR ALL STUDENTS

TETANUS-DIPTHERIA

1. Completed primary series of tetanus-diphtheria immunizations ______/______/______
2. Received tetanus-diphtheria booster **within the last 10 years** ______/______/______ or Tdap booster (recommended for ages 11-64 unless contraindicated) ______/______/______

MMR (Measles, Mumps, Rubella)

1. Dose 1 – Immunized at 12 months or before 5 years ______/______/______
2. Dose 2 – Immunized at 4 years or later (at least 28 days after first does) ______/______/______

POLIO, please circle vaccine type: Oral Inactivated

1. Completed primary series of polio immunizations ______/______/______

Hepatitis B

1. Dose #1 ______/______/______ Dose #2 ______/______/______ Dose #3 _____/______/______

OR Surface antibody ______/______/______ Result: Reactive ________Non-reactive_________

MENINGITIS VACCINE "A, C, Y, W" (Required by Maryland law for college students)

1. Name of vaccine: ____________________Date ______/______/_______
2. Booster required if original dose given before 16. Date ______/______/______

VARICELLA (CHICKEN POX)

Disease? Yes______Date:______/______/______ if date unknown provide titer result Reactive (date): ______/______/______

Non-Reactive(date): ______/______/______ OR

Vaccine: Dose #1 ______/_____/______ Dose #2______/______/______

RECOMMENDED (not required)

COVID VACCINE: COVID vaccine (1 dose): Type___________________________ Date_______________

COVID vaccine (2-dose): Type_________ Date #1________________ Date #2_______________

COVID Booster Type: ______________ Date________

HEPATITIS A

Immunizations (Hepatitis A) Dose #1______/______/______ Dose #2 ______/______/______ OR

Immunizations (Combined Hepatitis A and B)

Dose #1 ______/______/______ Dose #2 ______/______/______ Dose #3 ______/______/______

HUMAN PAPILLOMAVIRUS VACCINE (HPV)

Name of Vaccine: ______________________________

Dose #1 ______/______/______ Dose #2 ______/______/______ Dose #3 ______/_______/______

MENINGITIS B VACCINE

Name of Vaccine: ______________________________

Dose #1 ______/______/______ Dose #2 _______/______/_____ Dose #3 ______/_______/______

Health Care Provider Signature____**Date**____________________

Address____**Phone**______________________