Name: _____

Cell : (Student)_____

Marywood

UNIVERSITY

STUDENT HEALTH SERVICES

Physical Examination
Immunization Record

THESE FORMS ARE MANDATORY AND DUE BY AUGUST 1

PLEASE UPLOAD COMPLETED FORMS TO YOUR STUDENT HEALTH PORTAL

https://marywood.medicatconnect.com/login.aspx

Lead On.

PHYSICAL EXAMINATION

*****This section is to be completed and signed by an MD, DO, PA-C, or a NP*****

Last Name	First	Middle	Sex
Blood Pressure ____/____	Pulse ____/____	Height _____	Weight _____
Visual Acuity	(R) 20 / _____	(L) 20 / _____	

SYSTEMS REVIEW

	Normal	Abnormal	Describe Abnormalities
Skin	_____	_____	_____
HEENT	_____	_____	_____
Lymph Nodes	_____	_____	_____
Neck	_____	_____	_____
Heart	_____	_____	_____
Lungs	_____	_____	_____
Respiratory	_____	_____	_____
Gastrointestinal	_____	_____	_____
Genitourinary	_____	_____	_____
Reproductive	_____	_____	_____
Endocrine	_____	_____	_____
Musculoskeletal	_____	_____	_____
Neuro/Psych	_____	_____	_____

GENERAL COMMENTS:

Is there any loss or seriously impaired function of any paired organ? Yes _____ No _____

Recommendations for physical activity (PE, Intramurals)

Unlimited _____ Limited _____ Explain: _____

_____

Do you have any recommendations regarding the care of this patient? _____

_____

Is this patient now under treatment for any medical or emotional condition?_____

_____

This patient is free of communicable disease Yes ❑ No ❑

HEALTH PROVIDER'S SIGNATURE _____**MD ❑ DO ❑ PA-C ❑ NP ❑**

DATE OF PHYSICAL EXAM _____

Health Provider's Name (please print) _____

Address: _____

Telephone Number: (_____) - _____ Fax: (_____) - _____

IMMUNIZATION RECORD

*****This section is to be completed and signed by an MD, DO, PA-C, or a NP*****
Day, month and year must be completed.

_____
Last Name First Middle

IMMUNIZATIONS MUST BE UPDATED AS SPECIFIED BELOW.

A. TETANUS-DIPHTHERIA

1. ❑ Completed primary series of tetanus-diphtheria immunizations . . . . . _____/_____/_____
2. ❑ Received diphtheria, pertussis, tetanus booster within the last 10 years . . . . . Td:_____/_____/_____
   Tdap:_____/_____/_____

B. M.M.R. (Measles, Mumps, Rubella)

1. ❑ Dose 1 - Immunized at 12 months . . . . . _____/_____/_____
2. ❑ Dose 2 - Immunized at 4-6 years and at least one month after first dose . . . . . _____/_____/_____

C. Hepatitis B Vaccine (three doses or a positive Hepatitis B surface antibody titer meets the requirement).

❑ Dose 1 . . . . . _____/_____/_____
❑ Dose 2 . . . . . _____/_____/_____
❑ Dose 3 . . . . . _____/_____/_____

D. Varicella

❑ History of disease . . . . . _____/_____/_____
❑ Vaccine Dates: Dose 1 ..... _____/_____/_____ Dose 2 . . . . . _____/_____/_____

E. Tuberculosis Screening (PPD regardless of prior BCG inoculation). A two step, within a 3-week interval, is required for all Nursing, Nutrition/Dietetic, Athletic Training, and Physician Assistant Students in **sophomore year**.

1. PPD (Mantoux) Test within the past year (**Tine or monovac not acceptable**).
   PPD #1 Date Given: _____/_____/_____ Result: : ❑ Positive ❑ Negative
   PPD #2 Date Given: _____/_____/_____ Result: : ❑ Positive ❑ Negative
2. **Positive PPD – Chest x-ray required. Must submit a copy of the chest x-ray reading.**

F. Polio

❑ Completed primary series of polio immunizations: _____Yes _____ No
❑ Type of vaccine: _____ Oral _____ Inactive _____ E-IPV
❑ Last Booster . . . . . _____/_____/_____

G. Meningitis – Pennsylvania law mandates that ALL students living in university owned housing be immunized or sign a waiver after receiving information on the disease and vaccine.

❑ Vaccine1 _____/_____/_____ ❑ Vaccine 2 _____/_____/_____

H. Influenza . . . . . _____/_____/_____

HEALTH CARE PROVIDER

Name: _____ Address: _____

Signature: _____ **MD** ❑ **DO** ❑ **PA-C** ❑ **NP** ❑ Phone: ( ) _____