University Health Center
Physician's Health Evaluation

ALL STUDENTS MUST HAVE THIS PHYSICAL FORM COMPLETED PRIOR TO ATTENDING CLASSES AT CAIRN UNIVERSITY.

TO THE EXAMINING PHYSICIAN: Please review the student's health history and complete **both sides** of this form. Please comment on all positive answers. The information you supply will not affect his or her status; it will be used only as a background for providing necessary health care. This information is strictly for the use of Cairn University's Health Center and Athletic Department and will not be released without student consent.

PLEASE PRINT

Student's Full Name: _____ Sex: ☐ Male ☐ Female

Height: _____ Inches Weight: _____ Lbs. BP: _____ / _____

Corrected Vision:

Right 20/: _____ Left 20/: _____ Contact Lenses: _____ Glasses: _____

Urinalysis:

Sugar: _____ Albumin: _____ Micro: _____

ARE THERE ANY ABNORMALITIES OF THE FOLLOWING SYSTEMS?

	YES	NO		YES	NO		YES	NO
Head, Ears, Nose, or Throat	☐	☐	Hernia	☐	☐	Metabolic/Endocrine	☐	☐
Eyes	☐	☐	Genitourinary	☐	☐	Skin	☐	☐
Respiratory	☐	☐	Musculoskeletal	☐	☐	Is there loss or seriously		
Cardiovascular	☐	☐	Neuropsychiatric	☐	☐	impaired function of any		
Gastrointestinal	☐	☐	Neuropsychiatric	☐	☐	paired organ?	☐	☐

If you answered yes to the above question, please describe fully: _____

Do you find any reasons which would make it medically inadvisable for the student to participate in supervised athletic activities? ☐ Yes ☐ No

If yes, please explain: _____

Recommendations for physical activity: ☐ Unlimited ☐ Limited

If limited, please explain: _____

Do you have any recommendation regarding the care of this student? ☐ Yes ☐ No

If yes, please explain: _____

Is the patient now under treatment for any medical or emotional condition? ☐ Yes ☐ No

If yes, please explain: _____

BY SIGNING THIS FORM, I HEREBY AFFIRM THAT THE INFORMATION CONTAINED HEREIN CONCERNS THE STUDENT LISTED ABOVE AND IS A TRUE ACCOUNT TO THE BEST OF MY KNOWLEDGE.

Physician's or Nurse Practitioner's Signature: _____

Address: _____

Last Name (please print): _____ Date: _____

RETURN ALL INFORMATION TO: University Health Center, Cairn University, 200 Manor Avenue, Langhorne, PA 19047-2990

REV. 08/12

University Health Center
Record Immunizations

EVERY ITEM ON THIS PAGE MUST BE COMPLETED BY YOUR PHYSICIAN OR NURSE PRACTITIONER PRIOR TO ATTENDING CLASSES AT CAIRN UNIVERSITY.

NOTE WELL:

1. **Dates are Important** for all immunizations. Please include month, day, and year. This form is not complete without dates.
2. For measles, mumps, or rubella, immunizations are **required** or you must have proof of immunity (either had the disease or laboratory confirmation of immunity).
3. If your immunization records are not available, please have all your booster shots up to date or laboratory tests confirming immunity. (Contact your high school for a record of immunizations.)

Student's Full Name: _____ Student's Date of Birth (Month/Day/Year): _____/_____/_____

REQUIRED:

MMR* (Measles, Mumps, Rubella)

First: _____ / _____ / _____ Second required: _____ / _____ / _____

If born before 1957, you are considered immune to measles, mumps, and rubella.

POLIO

First: _____ / _____/_____ Second:_____ / _____ / _____ Third:_____/_____/_____ Latest Booster:_____/_____ / _____

Childhood Series—give all dates

DIPHTHERIA TETANUS PERTUSSIS

First: _____ / _____/_____ Second:_____ / _____ / _____ Third:_____/_____/_____ Latest Booster:_____/_____ / _____

Childhood Series—give all dates (Must be within the last 10 years.)

TB TEST

Mantoux Test (Date Given): _____ / _____ / _____ Date of Results:_____/_____/_____ Results: _____ mm

(Must be done within the last year.)

Chest X-ray if indicated (Date Taken):_____/_____ / _____ Results: _____

OPTIONAL:

HEPATITIS B**

First: _____ / _____/_____ Second:_____ / _____ / _____ Third:_____/_____/_____

MENINGITIS* Meningococcal Vaccine Tetravalent (A, C, Y, W-135) conjugate preferred**

Date of Vaccination:_____/_____/_____ Name of Vaccine:_____/_____/_____ Latest Booster:_____/_____/_____

New Policy Regarding Meningitis Immunization:

Cairn University will follow the new protocol for Meningococcal conjugate vaccines, quadrivalent (MCV4), as recommended by the CDC and the American College Health Association. If the first dose is administered at age 16 years or older, a booster dose is not needed. For more info about the Meningitis vaccine by the CDC visit http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-mening.pdf. Thank you for your cooperation.

CHICKEN POX** (Varicella Vaccine)**

First: _____ / _____/_____ Second:_____ / _____ / _____

* The following CDC guidelines for measles must be followed. Students should have two doses of the live virus measles vaccine. The first dose needs to be given at 12 months of age or later (even one day before the first birthday is not valid). The second dose should be given at the time of school entry or later. If the vaccine is received at other than the suggested schedule, the two doses must be received at 12 months of age or later and be separated by at least one month. Current laboratory evidence of immunity is acceptable.

** *Hepatitis B Virus* (HBV) is a potentially life-threatening bloodborne pathogen. Centers for Disease Control and Prevention (CDC) estimate there are approximately 280,000 HBV infections each year in the U.S. (December 1991). Approximately 8,700 health care workers each year contract Hepatitis B, and about 200 will die as a result. In addition, some who contract HBV will become carriers, passing the disease on to others. Carriers also face a significantly higher risk for other liver ailments which can be fatal, including cirrhosis of the liver and primary liver cancer. HBV infection is transmitted through exposure to blood and other infectious body fluids and tissues. Anyone with occupational exposure of blood is at risk for contracting the infection.

*** According to the CDC, there has been a sharp rise in meningitis outbreaks in the U.S. since the early 1990s, over one third of them occurring in organizational settings, including schools and universities. Fortunately, this type of meningococcal infection may be prevented with Menomune, a simple and effective one-dose vaccine.

****College students without evidence of immunity (e.g., born in the U.S. before 1980, a history of the disease, two prior doses of Varicella Vaccine, or a positive antibody titer) are recommended by the CDC to receive two (2) doses of the Varicella Vaccine.

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