

Name: \_\_\_\_\_

Please indicate your student status:

\_\_\_ Freshman \_\_\_ Sophomore \_\_\_ Junior \_\_\_ Senior \_\_\_ First year @Concordia \_\_\_ Transfer Student \_\_\_ Returning Student

# CONCORDIA COLLEGE NEW YORK

## Physical Examination

(must be completed by health care provider)

To the examiner: Please review the student's history and immunization record and complete form. Please comment on all positive answers. The information provided will be used only as a background for health care.

### Immunization Record (Include all dates)

	Yes	No	Dates					
DTP	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
Dt/Td	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
Measles	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
or MMR*								
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
Polio	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
Meningococcal	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
Varicella	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____

\*if born after 12/31/1956, it is required to have proof of 2 measles (Rubeola) vaccines. It may be on your records as MR or MMR.

Meningococcal disease (bacterial meningitis) is a serious, often fatal infection of the brain. College students, especially freshmen, living in dormitories are at greater risk. Receiving meningococcal vaccine prevents meningitis.

Please read and sign: I have read the above and I understand that I must receive meningitis vaccine to live in a Concordia dormitory.

Signature: \_\_\_\_\_

### Tuberculin Skin Test (PPD only)

To have been done within 6 months – mandatory for all incoming students

Date Planted: \_\_\_\_\_

Date Read: \_\_\_\_\_

Results in mm: \_\_\_\_\_

Signature of Practitioner: \_\_\_\_\_

(If Chest X-ray was done, please attach copy of report.)

### Urinalysis

Glucose: \_\_\_\_\_

Protein: \_\_\_\_\_

Blood: \_\_\_\_\_

Hemoglobin: \_\_\_\_\_

Are there any abnormalities of the following areas? Please comment on all positive answers.

	Yes	No	Comments
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head, ears, nose, and throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Metabolic/Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuropsychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____

Name \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Correct vision: Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_

Recommendations for physical activity (PE, Intramurals)                      Unlimited                      Limited                      Explain: \_\_\_\_\_

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Do you have any recommendations regarding the care of this student?

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Is the patient now under treatment for any medical condition?

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Additional Comments

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Provider's Signature: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Print Last Name: \_\_\_\_\_ Date: \_\_\_\_\_