

Name: _____

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)

Copies of all titers must be attached.

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

Height: _____ Weight: _____ Blood Pressure: _____
Correct vision: Right 20/_____ Left 20/_____

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

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

Is the patient now under treatment for any medical condition?

Additional Comments

Provider's Signature: _____ Telephone: _____

Address: _____

Print Last Name: _____ Date: _____