PHYSICAL EXAM

ALL STUDENTS: A physical exam is required within 12 months prior to the first day of class at Muhlenberg College.
VARSITY ATHLETES: A physical exam is required within 6 months prior to the start of fall practices at Muhlenberg College.
Physical Exam and Immunization Record will be disclosed to and used by Health & Counseling Services and Sports Medicine

Student's Legal Name:_____ **DOB:**_____ **Preferred Name:** _____
Sex assigned at birth:_____ **Gender Identity:**_____**Pronouns:**_____ **Athletes – Sport:** _____

Section I: Physical Exam (Required)

Exam Date: _____ Height _____ Weight: _____BMI: _____ B/P :_____ Pulse:_____
Pupils: ❑Equal ❑Unequal Vision: R 20/ _____ L20/ _____ Corrected: ❑Yes ❑No

	NORMAL	ABNORMAL FINDINGS (describe) or COMMENTS
Skin		
Eyes/Ears/Hearing/Nose/Throat		
Respiratory/ Lungs		
Cardiovascular: Heart rhythm ❑ Normal ❑Abnormal • Heart murmur ❑No ❑Yes If yes, specify: ❑ Systolic Murmur or ❑ Diastolic Murmur, Location_____ Grade (I-VI) _____ Does murmur increase with Valsalva? ❑ No ❑Yes • Pulses ❑ Normal ❑Abnormal. Any delay in femoral pulses? ❑ No ❑ Yes • Marfan Criterias (Chest deformities, long arms and legs, wrist/joint hyperflexibility, flat footedness, scoliosis, lens dislocation, high arched palate, etc): ❑ No ❑Yes Abnormal Findings or Comments: _____		
Abdomen		
Genitourinary/Testicles/ Hernia		
Musculoskeletal		
Neurologic		# of Concussions: _____
Emotional		

Section II: Health History (Required. All questions must be answered. Attach additional sheet, if needed)

- Take any medications? If yes, please list med, dose, frequency. ( )NO ( )YES _____
  _____
- Any allergies (medicine, food, environmental)? ( )NO ( )YES, explain_____
- History of Anaphylaxis? ( )NO ( )YES, what was the trigger? _____ Carry an EpiPen or AuviQ? ( )NO ( )YES
- Have a loss or seriously impaired function of any paired organ? ( )NO ( )YES, explain _____
- Medical & Surgical History(include treatment for any medical or psychologic condition)_____
  _____
- Any general comments or recommendations that may be important for the care of this student _____
  _____

Section III: Tuberculosis Risk Assessment (Required) #1 and #2 must be answered, If Yes, PPD or IGRA required.

1. **Does the student have signs or symptoms of active tuberculosis disease?** ( )NO ( )YES, explain_____
   If YES, proceed with additional evaluation to exclude active tuberculosis disease including chest x-ray (PA and lateral) and sputum evaluation as indicated.
2. **Is the student a member of a high-risk group, or ever had close contact with persons known or suspected to have active TB disease, or lived in/visited high-risk regions such as South America, Central America, Asia, parts of Europe, or Africa?** ( )NO ( )YES

***If Yes to #1 or #2 , IGRA or PPD (Mantoux) test required. Must complete below.**
Interferon Gamma Release Assay (IGRA) Date obtained:_____ Specify method: ☐QFT-GIT ☐T-Spot
Result: ☐ Positive ☐ Negative ☐ Indeterminant ☐Borderline (T-Spot only)

Tuberculin Skin Test (PPD) Date given (within the 6 months of college entrance) _____
Date Read _____Result: _____ (mm of induration) ☐ Positive ☐ Negative

CHEST X-RAY REQUIRED (if tuberculin skin test or IGRA is positive). X-Ray result: ☐ Normal ☐ Abnormal Date: _____
Treatment (Include treatment and dates)_____

Section IV - Varsity Athletes only: Varsity Sports Clearance (must include EKG and Sickle Cell Trait Results)

❑Cleared without restriction
❑Cleared with restriction. Specify:_____
❑Not Cleared. Include reason:_____

Date: _____ Health Care Provider Signature:_____
Health Care Provider Name_____Telephone: _____

IMMUNIZATION RECORD

If the immunization requirements are not met, the student will NOT be permitted to obtain their residence hall key. Please record dates (month/day/year) below and include a copy of vaccine records from student's medical provider.

Student's Legal Name: _____**Preferred Name**_____**Date of Birth:** _____

Required Immunizations	1st Dose	2nd Dose	3rd Dose	4th Dose
Hepatitis B 3 dose series is required. A blood test (titers) showing immunity is acceptable (upload lab result).				
Meningitis Quadrivalent (Serogroup A,C,Y,W-135) Menactra, Menveo, or MenQuadfi At least one dose must be on or after age 16 years				
MMR (Measles/Mumps/Rubella) Two doses required at least 28 days apart after 12 months of age. Or blood tests showing immunity is acceptable (upload lab report).				
Varicella (chicken pox) 2 doses required Or **History of having the disease on this date** Or a blood test (titer) showing immunity is acceptable (upload lab report).				
	Date of disease			
Tdap Booster (Tetanus/Diphtheria/Pertussis) within past 10 years & on or after age 10 years				
Polio (OPV or IPV) Primary series of 3 or 4 doses in childhood				

Recommended Immunizations (not required)				
COVID-19 Primary Series and Booster(s) (Specify vaccine type in box)				
Hepatitis A				
HPV (Human Papillomavirus Vaccine)				
Influenza (annually)				
Meningitis Serogroup B Circle type: Bexsero or Trumemba				

I certify that to the best of my knowledge the information on the Immunization Record is true and complete.

Date: _____ Healthcare Provider Signature:_____

Healthcare Provider Name: _____

Address: _____

Telephone:_____ Fax: _____

This page must be completed for

Varsity Athletes Only

Student's Legal Name:_____**Preferred Name:** _____**DOB:**_____

Health Care Provider: COMPLETE FOR VARSITY ATHLETES ONLY

Sickle Cell Trait Status Physician Verification

NCAA requires confirmation of sickle cell trait status for all Division III athlete

❑I verify that the above named individual has been tested for sickle cell trait.

Date of Sickle Cell Trait Testing _____

Results: ❑Positive ❑Negative

❑**Copy of lab results given to student.**

Electrocardiogram

12-lead Resting ECG/EKG Required. Please attach interpretable copy of ECG.

❑**Copy of ECG given to student.**

Date: _____ Health Care Provider Signature:_____

Health Care Provider Name & Address: _____

Provider Telephone Number: _____ Provider Fax:_____