Due date:
Fall - August 1st; Spring - January 1st

Queen Anne Building
300 Washington Avenue
Chestertown, MD 21620
Phone 410-778-72 61 Fax 410-810-7101
health_services@washcoll.edu
washcoll.studenthealthportal.com

STUDENT HEALTH FORM

FOR LICENSED HEALTHCARE PROVIDER TO COMPLETE

TO THE EXAMINING HEALTH CARE PROVIDER: Please review the student's history and complete this report. Please comment on all positive answers. *This student has been accepted.* The information supplied *will not* affect his/her status. It will be used as a background for providing continued physical and mental health care on campus. **Physical Exam must be done within 6 months prior to arriving on campus.**

Name_____ **Date of Birth**_____ **Current Gender Identity**_____

Height_____ **Weight**_____ **Blood Pressure**_____ **Pulse**_____

Allergies_____

Current medications_____

_____

Visual Acuity: Recommended

□ With □Without Correction

□ Glasses □ Contact Lenses

Right 20/ Left 20/ Both 20/

Clinical Evaluation	Normal	Record Abnormal Findings .....
Appearance (Report Marfan Stigmata)		
Skin		
Head, ears, Eyes, Nose, Hearing		
Mouth, Teeth and Gums		
Neck and Thyroid		
Lungs/Chest		
Breasts		
Heart (supine and standing)		
Abdomen		
Genitalia		
Back/Spine		
Extremities/Musculoskeletal		
Neurologic		
Emotional/Psychological		

A Is this student cleared for physical activity including use of the fitness facilities and classes, intramural, club or intercollegiate sports and able to meet the physical and emotional demands of college life include studying abroad? □ YES □NO- Limited Explain_____

Sickle Cell Screen Required for all Varsity Athletes Test date_____ □Positive □Negative

B Tuberculosis (TB) Screen-Required for all students- 1. Any signs or symptoms of active TB disease? □Yes Proceed with additional evaluation to exclude active TB disease including PPD testing, IGRA, CXR and sputum evaluation as indicated, copies of results must be attached.

□No→ 2. Is this student a member of a high risk group or an international student from a high risk country as defined by the CDC? □ Yes-CXR required, copy of results is required and all Treatment Plans for positive findings (including information about INH Therapy) must be attached. □No- No further TB testing required

C Is this student under care (by any provider) for any physical or emotional conditions? □ NO

□ YES describe_____

Surgeries_____ Dietary Restrictions_____

I have reviewed the medical history, immunizations, conducted the TB screen and examined this student. The information on this form is accurate, full and complete to the best of my knowledge. Sign_____ Date_____

Print Provider's Name_____Phone_____ Fax_____

Office Address_____

TUBERCULOSIS SCREENING AND IMMUNIZATION INFORMATION

Name _____
Last First MI
Date of Birth _____
month/day/year social security # Phone

Part II To be completed and signed by a Health Care Provider (Include month, day, year and translate all lab work and results in English)

IMMUNIZATION REQUIRED FOR ALL STUDENTS

A. for international students only

1. BCG vaccine received? no____ yes___ date given_____ / _____ / _____

B. TETANUS-DIPHTHERIA

1. Completed primary series of tetanus-diphtheria immunizations _____ / _____/ _____
2. Received tetanus-diphtheria booster **within the last 10 years** _____ / _____/ _____

or Tdap booster (recommended for ages 11-64 unless contraindicated) _____ / _____/ _____

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

1. Dose 1 - Immunized at 12 months or before 5 years _____/_____/ _____
2. Dose 2 - Immunized at 4 years or later (at least 28 days after first dose) _____ / _____/ _____

D. POLIO please circle vaccine type: Oral Inactivated

1. Completed primary series of polio immunizations ____ / _____ / _____ Last booster _____ / _____/ _____

E. HEPATITIS B

1. Dose #1 _____/ _____/_____ Dose #2 _____ / _____/ _____ Dose #3 _____ / _____ / _____

OR Surface antibody _____/_____ / _____ Result: Reactive _____Non-reactive _____

F. MENINGITIS VACCINE (Required by Maryland law for college students)

1.Name of vaccine: _____ Date ____ / _____/ _____
2.Booster required if original dose given before 16 Date ___ / _____ / _____

G. VARICELLA (Chicken Pox)

Disease? Yes_____ Date: ____ / _____/ _____ if date unknown provide titer results and
Reactive (date):____/ _____/_____ NonReactive (date):_____/ _____/_____
Vaccine: Dose #1 _____ / _____ / _____ Dose #2 _____/ _____ / _____

H. COVID VACCINE: COVID vaccine (1 dose): Type_____ Date_____

OR

COVID vaccine (2-dose): Type_____ Date #1_____ Date #2_____

AND

COVID Booster Type:_____ Date_____ Fgqrmpw md f_tgle COVID? N/Y-Date_____

RECOMMENDED

G, HEPATITIS A

/, Immunization (Hepatitis A) Dose #1 _____ / _____ / _____ Dose #2_____ / _____ / _____

0, Immunization (Combined Hepatitis A and B)

Dose #1 _____/ _____ / _____ Dose #2_____/_____ / _____ Dose #3 _____/_____/_____

GG, HUMAN PAPILLOMAVIRUS VACCINE (HPV4)

Name of vaccine: _____

Dose #1 _____/ _____ / _____ Dose #2 _____/_____ / _____ Dose #3 _____/_____/_____

GGG, MENINGITIS B VACCINE

Name of vaccine: _____

Dose #1 _____/ _____ / _____ Dose #2 _____/_____ / _____ Dose #3 _____/_____/_____

Health Care Provider _____

_____

Signature Date

Address _____

Phone _____