

SAINT JOSEPH COLLEGE HEALTH PHYSICAL EXAMINATION FORM

Name				DOB				Date of exam <i>(within 12 months)</i>		LMP	
Height		Weight		BP		Pulse		H/H			

PHYSICAL EXAMINATION REPORT

HEENT		Back/Spine	
Neck/Thyroid		Musculoskeletal	
Heart		Neurological	
Lungs		GU/GYN	
Breasts		Skin	
Abdomen		Psychological	
Lymphatics		Other	

IMMUNIZATIONS *RECORD DATES OR ATTACH VACCINE RECORDS*

Required: All students born after 12/31/56 must submit 2 MMR's or all equivalent vaccines shown	MMR # 1	MMR # 2	[] Lab titer results attached
	Measles # 1	Mumps # 1	Rubella # 1
	Measles # 2	Mumps# 2	Rubella # 2
Required: Resident students including international/visiting.	Meningitis	Booster date	(recommended when # 1 given before age 16)
	Recommended	DTP	Td booster or Tdap booster
Recommended	Polio		
Required: Health Sciences students, recommended all others	Hepatitis #1	Hepatitis# 2	Hepatitis # 3
	Required: All students born in US after 12/31/79. If born outside US, must present titer or 2 vaccines	Varicella (chickenpox) # 1	Varicella # 2
OR Month _____ Year _____ Natural disease occurred			
Required: International/Health Sciences students	PPD date/results _____ If positive, attach x-ray report & any treatment records.		

If lab titers drawn, laboratory original reports must be attached. MMR (and related vaccines) and Varicella vaccines must be given after age 1 year to be accepted. Measles vaccines given before 1968 or Rubella vaccines given before 1969 cannot be accepted. Health Sciences programs are: Dietetic Internship, Nursing & Pharmacy. Health Sciences students are not eligible for birth date related exemptions for MMR.

PROVIDER COMMENTS *PLEASE CHECK ALL THAT*

<input type="checkbox"/>	Student medical history reviewed on opposite side of form.
<input type="checkbox"/>	Able to participate in all classes, academic activities including required physical education course.
<input type="checkbox"/>	Can participate in intercollegiate athletics. Please complete Athletic department pre-participation physical examination form.
<input type="checkbox"/>	Free of communicable disease and can participate clinical rotations in health care facilities.
<input type="checkbox"/>	Additional provider comments or recommendations including restrictions, treatment plans, etc.

MEDICATIONS *Include dose and frequency, and attach a separate page if more space required.*

<i>Affix office stamp or print provider name & address</i>	<i>Signature</i> <i>Date</i>
	<i>Telephone</i> <i>Fax</i>
<i>Return forms to: Saint Joseph College Health Services, 1678 Asylum Avenue, West Hartford, CT 06117 or Fax: 860.231.6794</i>	

SAINT JOSEPH COLLEGE STUDENT MEDICAL HISTORY FORM

Name		Birth date	/ /	Birth place	
Street/ Apartment		Gender		Marital status	
City/State		Home Telephone			
Zip		Mobile Telephone			
Email Address					

PERMISSION TO TREAT

	I give my permission to authorized representatives of Saint Joseph College to arrange for medically advised urgent care if I or my designated emergency contact are unable to provide consent for treatment.				
	I give Saint Joseph College Health Services staff to administer routine medical treatments, first aid and/or emergency care to me.				
Student Signature		Date			
Parent Signature	<i>If student less than 18 years old</i>	Date			

EMERGENCY CONTACT INFORMATION *Please print*

Person to notify		Relationship	
Address		Home Telephone	
Work Telephone		Mobile Telephone	

STUDENT MEDICAL HISTORY *Please check all that apply. If you have a condition not listed please provide detail in space below.*

Measles		Arthritis (or Lyme Disease)		Seizures	
Mumps		Allergy (food/drug/latex)		Sexually Transmitted Infection	
Rubella (German Measles)		Asthma		Diabetes	
Chickenpox (Varicella)		Eating Disorder		Heart Disease	
HIV/AIDS		Mononucleosis		Heart Murmur	
Dental Problems		Tuberculosis		High Blood Pressure	
Sickle Cell Anemia (or trait)		Thyroid Disorder		Anxiety or Panic Disorder	
Headache		Surgery/Operation		Substance Abuse	
Traumatic Injury		Menstrual Disorder		Hospitalization	
Depression		Physical Limitation		Tobacco Use/Smoking	

EXPLAIN ALL CHECKED ANSWERS INCLUDING MEDICATIONS AND TREATMENTS USED

Please check here if none of the above apply. Attach separate sheet if more space needed.

HEALTH INSURANCE INFORMATION

I am attaching my insurance card and will perform the online waiver annually. (Credit for the student insurance fee is only available when the online waiver procedure has been performed before the published deadline.)

I am not covered by another health insurance plan and understand that a student insurance fee is charged each semester and that I will be enrolled in the plan unless I perform the waiver procedure.