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

Queen Anne's Building
300 Washington Avenue
Chestertown, MD 21620
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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, O<R 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-OCR 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._____

IMMUNIZATION INFORMATION

Name:_____
Last **First** **MI**

Date of Birth:_____
Monrh/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 results in English) **IMMUNIZATIONS REQUIRED FOR ALL STUDENTS**

A. For International students
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) ____/____/____ Non-reactive (date) ____/____/____
Vaccine Dose 1 ____/____/____ Dose 2 ____/____/____

STRONGLY RECOMMENDED VACCINES:

I. HEPATITIS A
1. Immunization (Hepatitis A) Dose 1 ____/____/____ Dose 2 ____/____/____
2. Immunization (Combined Hepatitis A and B)

Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____

II. HUMAN PAPILLOMAVIRUS VACCINE (HPV4)

Name of vaccine: _____
Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____

III. MENINGITIS B VACCINE

Name of vaccine: _____
Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____

IV. COVID VACCINE

COVID vaccine (1 dose): Type _____ Date ____/____/____
OR
COVID vaccine (2 dose): Type _____ Date 1 ____/____/____ Date 2 ____/____/____
AND
COVID Booster: Type _____ Date ____/____/____ History of having COVID: N/Y-Date: ____/____/_____

Health Care Provider: _____ _____
Print Name/Signature **Date**

Address: _____
Phone: _____ Fax:_____