WASHINGTON & JEFFERSON COLLEGE PHYSICAL EXAMINATION FORM

Student Name: ______________________ Date of Birth: ______________________

Printed Name of Physician: ______________________ Phone Number: ______________________

Date of Exam: ______________________

Temp:	Pulse:	BP:	Height:	Weight:

	Normal	Abnormal	Describe Abnormalities
Head, Ears, Nose & Throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Eyes			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatry			
Skin			

Current Medications:	Medication Allergies:

Is this student under treatment for any physical or emotional conditions? Yes ☐ No ☐ ______________________

____

Cardiac Hx (murmur, palpitations, long QT syndrome, hypertension) Yes ☐ No ☐ ______________________

Family Hx of nontraumatic sudden death before age 50? Yes ☐ No ☐ ______________________

Prior Extertional Chest Pain? Yes ☐ No ☐ Prior Extertional Syncope? Yes ☐ No ☐ ______________________

Prior heat stress Hx? (dehydration, heat exhaustion, heat stroke) Yes ☐ No ☐ ______________________

Head injury Hx? (previous concussions or LOC,) If yes, please indicate the number and severity of espisodes Yes ☐ No ☐ ______________________

____

Pulmonary Hx? (Asthma, EIA, etc.) Yes ☐ No ☐ ______________________

Is the student cleared to participate in intercollegiate athletics? Yes ☐ No ☐

Is the student cleared to participate in physical education courses? Yes ☐ No ☐

Signature of Physician ______________________ Date ______________________

PLEASE COMPLETE IMMUNIZATION RECORD ON NEXT PAGE

IMMUNIZATION RECORD

To be completed by health care provider. (all information must be provided in English)

Required Immunization	Dates (Month/Day/Year)	Pennsylvania State Requirements
MMR OR OR Positive Titer	#1____/_____/_____ #2____/_____/_____ Measles #1____/_____/_____ #2____/_____/_____ Mumps #1____/_____/_____ #2____/_____/_____ Rubella #1____/_____/_____ #2____/_____/_____ ☐ Measles #1____/_____/_____ ☐ Mumps #1____/_____/_____ Attach Report ☐ Rubella #1____/_____/_____	2 doses of MMR (measles, mumps, and rubella). Single component vaccines or positive titers. Minimum of 4 weeks between doses. First vaccine dose cannot be given before first birthday.
Tdap	Adult Tdap ____/_____/_____ (Adacel or Boostrix)	Tetanus, Diphtheria, Pertussis vaccine within the past 10 years. Tetanus or Diphtheria only vaccine is not acceptable.
Meningitis ACWY	☐ Menactra ____/_____/_____ ☐ Menveo ____/_____/_____ ☐ Booster (if indicated) ____/_____/_____ ☐ Waiver Completed - Meningitis Waiver	If initial dose <16 years; booster dose at 16-18 years of age. If initial dose given age = or >16 years, no booster is needed. *Students must provide proof of immunization or sign waiver declining the vaccine via Medical History form.*
Hepatitis B Series OR Hepatitis B Titer	#1____/____/_____ #2____/____/_____ #3____/____/_____ ☐ pediatric dose or ☐ adult dose Hepatitis B Surface Antibody ____/____/____ Attach Report	Series of 3 age appropriate doses (given at 0, 1-2 mo., and 6-12 mo.) at any age. Adolescents age 11-15 years can be given 2 adult doses (given at 0 and 4-6 mo.)
Varicellla OR OR	#1____/____/_____ #2____/____/_____ Date of Disease ____/____/_____ Positive Titer Date ____/____/_____ Attach Report	Series of 3 age appropriate doses (given at 0, immunization, history of disease, or positive titer. 2 doses of vaccine at least 12 weeks apart if between the age of 1 and 12 years. 2 doses of vaccine at least 4 weeks apart if between the age of 13 years or older.
Polio	☐ Completed Primary Series ____/____/_____	Primary series in childhood with IPV alone. OPV alone or IPV/OPV sequentially.
COVID-19* *IF RECEIVED*	☐ Pfizer ☐ Moderna ☐ Janssen (Johnson &Johnson) #1____/____/_____ #2____/____/_____	

RETURN TO: W&J GATEWAY, W&J COLLEGE, 60. S. LINCOLN ST., WASHINGTON PA, 15301 OR BY FAX TO 724-229-5143