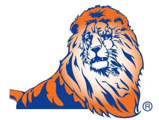
LINCOLN UNIVERSITY HEALTH SERVICES
Physical Examination Form



To The Student:

All Students listed are required to file this physical examination form in order to complete registration.

1. All incoming freshmen and transfer students.
2. Annually by all participants, men and women, in Intercollegiate Athletic Programs.
3. On request from Health Services, a student suffering from a chronic illness or a student whose status of health would be detrimental to his educational progress or to another college student.
4. This information is strictly for Health Services use and will not be released without your knowledge and consent.

MANDATORY - All students entering Lincoln University must fill out this form upon acceptance.

REPORT OF MEDICAL HISTORY
PLEASE COMPLETE THIS BEFORE GOING TO YOUR PHYSICIAN FOR YOUR EXAMINATION

LAST NAME (PRINT) | FIRST NAME | MIDDLE | SOC. SEC. NO. | SEX M/F

HOME ADDRESS (NUMBER AND STREET) | CITY OR TOWN | STATE | ZIP CODE | DATE OF BIRTH

STUDENT CELL PHONE NUMBER | HOME TELEPHONE NUMBER

EMERGENCY CONTACT PERSON | HOME NUMBER | CELL NUMBER | WORK NUMBER

RELATIONSHIP TO STUDENT | YEAR ENTERING LINCOLN UNIVERSITY | FALL OR SPRING SEMESTER

Does your religion prohibit treatment? ☐ Yes ☐ No

FAMILY HISTORY

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Has any of your relatives ever had any of the following?

	Yes	No	Relationship
Tuberculosis			
Diabetes			
Kidney Disease			
Arthritis			
Stomach Disease			
Asthma, Hay Fever			
Epilepsy, Convulsions			

PERSONAL HISTORY PLEASE ANSWER ALL QUESTIONS. Comment on all positive answers in space below or on an additional sheet.

HAVE YOU HAD	YES	NO	HAVE YOU HAD	YES	NO	HAVE YOU HAD	YES	NO	HAVE YOU HAD	YES	NO
Scarlet Fever			Insomnia			Pain/Pressure in Chest			Gallbladder Trouble or Gallstones		
Measles			Frequent Anxiety			Chronic Cough					
German Measles			Frequent Depression			Palpitations (Heart)			Recurrent Diarrhea		
Mumps			Worry or Nervousness			High or Low Blood Pressure			Recent Gain or Loss of Weight		
Chicken Pox			Recurrent Headache								
Malaria			Recurrent Colds			Rheumatic Fever or Heart Murmur			Dizziness, Fainting		
Gum or Tooth Trouble			Head Injury with Unconsciousness						Weakness, Paralysis		
Sinusitis						Disease or Injury of Joints			Venereal Disease		
Eye Trouble			Hay Fever						Albumin/Sugar in Urine		
Ear, Nose, Throat Trouble			Tuberculosis			"Trick" Knee, Shoulder etc.			Frequent Urination		
Surgery			Shortness of Breath			Back Problems					
Appendectomy			Allergy to the following			Tumor, Cancer, Cyst			Females Only		
Tonsillectomy			Penicillin			Jaundice			Irregular Period		
Hernia Repair			Sulfonamides			Stomach or Intestinal Trouble			Severe Cramps		
Other			Serum						Excess Flow		
			Foods (which)			Seizure/Epilepsy					
Asthma			Other			Sickle Cell					

	YES	NO
A. Has your physical activity been restricted during the past five years? (Give reasons and durations)		
B. Have you had difficulty with school, studies, or teachers? (Give details)		
C. Have you received treatment or counseling for a nervous condition, personality or character disorder or emotional problem? (Give details)		
D. Have you had any illness or injury or been hospitalized other than already noted? (Give details)		
E. Have you consulted or been treated by clinics, physicians, healers or other practitioners within the past five years? (Other than routine checkups?)		

	YES	NO
F. Do you have any questions in regard to your health, family history or other matters such as pre-marital counseling, which you would like to discuss now with a member of the staff of the Health Services?		

REMARKS OR ADDITIONAL INFORMATION (use additional sheet if necessary)

Student's Signature

Physician's Signature (Acknowledging Review) Date

Rev. 03/08

LINCOLN UNIVERSITY
HEALTH SERVICES
Physical Examination Form

To The Examining Physician:

Please review the student's history and complete the physician's form. Please comment on all positive answers. The information supplied will not affect his or her status: it will be used only as background for providing health care, if this is necessary. This information is strictly for the use of the Health Services Office and will not be released without student consent.

Last Name ____________ First Name ____________ Middle ____________ Sex ☐ M ☐ F

BP and Pulse ____________ Height ________ Weight (lbs.) ________ ☐ Overweight ☐ Underweight

Converted Vision: Right 20/______ Left 20/______ Year Entering Lincoln University ________ ☐ Fall ☐ Spring

Urinalysis

Sugar ____________

Albumin ____________

Micro ____________

Hemoglobin (if indicated)

____________ gms/%

Are there any abnormalities of the following systems?
Use additional sheet if needed.

	Yes	No
1. Head, Ears, Nose, or Throat	☐	☐
2. Respiratory	☐	☐
3. Cardiovascular	☐	☐
4. Gastrointestinal	☐	☐
5. Hernia	☐	☐
6. Eyes	☐	☐
7. Genitourinary	☐	☐
8. Musculoskeletal	☐	☐
9. Metabolic/Endocrine	☐	☐
10. Neuropsychiatric	☐	☐
11. Skin	☐	☐
Is there loss or seriously impaired function of any paired organ?	☐	☐

Immunization Requirements:
Failure to complete and return this form will prevent registration at Lincoln University.
Return of completed form is mandatory for all entering students.

1. Tuberculosis testing required within one year of admission.
   Date tested: ________ Result: ________
   If positive, attach copy of chest x-ray report.
   Was BCG vaccine given: ________ Date: ________
2. DT (diphtheria-tetanus) Booster required within five years of admission.
   Date given: ________
3. MMR (measles, mumps, and rubella) - Two (2) doses required after age 15 months.
   Void if born before 1957. Dose 1: ________ Dose 2: ________
   MMR titers: Date: ________ (positive / negative)
4. Menactra (meningitis - required as of 6/2003): Date: ________
5. Varicella (Chicken Pox): Blood Lab Titers Test: ________ (positive / negative)
   Note: Please attach a copy of the titers report. Required for validation. BY DISEASE IS NO LONGER ACCEPTED!
   (OR)
   Date of 1st dose: ________ Date of 2nd dose: ________

Recommended:

1. Hepatitis B
   Dose #1: ________ Dose #2: ________ Dose #3: ________
2. Polio
   Series complete: ________ Date of last Booster: ________

Present Medication Taking / comments: ____________

Recommendations for physical activity (PE, Intramurals, ROTC) ☐ Unlimited ☐ Limited Explain: ________

Do you have any recommendations regarding the care of this student? ☐ Yes ☐ No
Is the patient now under treatment for any medical or emotional condition? ☐ Yes ☐ No

Physician's Signature ____________

Address ____________

Print Last Name ____________ Date ________

This recommendation has been approved by the Liaison Committee of the American College Health Association and the American Medical Association and Approved by the American College Health Association.

Return this information in the self-addressed envelope to:
Lincoln University Health Service
MSC 135, P.O. Box 179
Lincoln University, PA 19352-0999
office # 484-365-7338 or 7327
fax # 484-365-7287

Rev. 03/08