



Lincoln University Health Services

Physical Examination Form

MANDATORY – All entering students MUST have a completed Personal Health History on file (incoming freshman, transfer students, and re-admits). Please complete this page before going to your physician for your examination; physician MUST sign this form indicating that he/she has reviewed the Personal Health History. This information is strictly for Health Services use and will not be released without your knowledge and/or consent. This form must be updated:

- Annually (every year in August) by all participants (men and women) in Intercollegiate Athletic Programs, and
- On request from Health Services, a student suffering from a chronic illness or a student whose status of health would be detrimental to his or her educational progress or to that of another college student.

 LAST NAME (PLEASE PRINT LEGIBLY) FIRST NAME MIDDLE INITIAL COLLEGE ID NUMBER GENDER

 HOME ADDRESS CITY OR TOWN STATE ZIP CODE DATE OF BIRTH

 STUDENT'S CELL PHONE NUMBER STUDENT'S HOME PHONE NUMBER SEMESTER ENTERING (FALL OR SPRING) YEAR

 EMERGENCY CONTACT PERSON RELATIONSHIP TO STUDENT HOME PHONE NUMBER CELL PHONE NUMBER WORK PHONE NUMBER

DOES YOUR RELIGION PROHIBIT ANY TYPE OF MEDICAL TREATMENT? YES NO

Family History (The following questions relate to Parents, Grandparents, and Siblings)

	Age	Condition of Health	Occupation	Age at Death	Cause of Death		Yes	No	Relationship to Student
Father						Tuberculosis			
Mother						Diabetes			
Bro/Sis						Kidney Disease			
Bro/Sis						Arthritis			
Bro/Sis						Stomach Disease			
Bro/Sis						Asthma, Hay Fever			
Bro/Sis						Epilepsy,			
Bro/Sis						Convulsions			

PERSONAL HEALTH HISTORY (Please answer all questions; comment on all positive answers on a separate sheet of paper)

HAVE YOU HAD	YES/NO	HAVE YOU HAD	YES/NO	HAVE YOU HAD	YES/NO	HAVE YOU HAD	YES/NO
Scarlet Fever		Insomnia		Pain and/or Pressure in Chest		Gallbladder Trouble or Gallstones	
Measles/ Rubeola		Frequent Anxiety		Chronic Cough		Recurrent Diarrhea	
German Measles/Rubella		Frequent Depression		Heart Palpitations		Recent Weight Gain or Loss	
Mumps		Worry or Nervousness		High or Low Blood Pressure		Dizziness and/or Fainting	
Chicken Pox		Recurrent Headaches		Rheumatic Fever or Heart Murmur		Weakness or Paralysis	
Malaria		Recurrent Colds		Disease or Injury of Joints		Venereal Disease	
Gum and/or Tooth Trouble		Head Injury w/Unconsciousness		"Trick" Knee or Shoulder		Stomach and/or Intestinal Trouble	
Hay Fever or Sinusitis		Tuberculosis		Back Problems		Frequent Urination	
Eye Trouble		Shortness of Breath		Tumor, Cancer, or Cyst		Females Only:	
Ear, Nose, Throat Trouble		Asthma		Jaundice		Irregular Periods	
Surgery:		Inhaler and/or Nebulizer Use		Seizure, Epilepsy		Severe Cramps	
Appendectomy		Name of Med		Anemia		Excessive Flow	
Tonsillectomy				Sickle Cell		Birth Control	
Hernia Repair		How Often Used		Drug Allergies		Depo Provera	
Any Other Surgery				Penicillin		Birth Control Pills	
Food Allergies		Seasonal Allergies		Sulfonamides		Nuva Ring	
		Allergy Injections		Serums		IUD	

	YES/NO
Has your physical activity been restricted during the past five years? (If yes, give reasons and duration)	
Have you had difficulty with school, studies, or teachers? (If yes, give details)	
Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problems? (If yes, give details)	
Have you had any illness or injury or been hospitalized other than already noted? (If yes, give details)	
Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years other than routine check-ups?	

STUDENT'S SIGNATURE (IF STUDENT IS A MINOR, PARENT OR GUARDIAN SIGNATURE IS REQUIRED) _____ DATE _____

PHYSICIAN'S SIGNATURE (I ACKNOWLEDGE THAT I HAVE REVIEWED THIS FORM) _____ DATE _____

**Lincoln University Health Services
Physical Examination Form**

To The Examining Physician:

Please review the student's health history and complete the physical examination form. Please comment on all positive answers. The information supplied will be used 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 Initial _____ Gender _____

Temperature _____ Pulse _____ Respirations _____ Blood Pressure _____ Height _____ Weight _____

Vision _____ (Right Eye) _____ (Left Eye) Semester Entering (Fall or Spring) _____ Year _____

IMMUNIZATION REQUIREMENTS: Failure to complete and return this form will delay registration. Return of completed form is MANDATORY for ALL entering students.

Tuberculosis (Testing required within one year of admission) Date Administered: _____ Reading date & results: _____
 (If positive, must have a negative chest x-ray report attached) (If Quantiferon Gold test is done, must attach report) **negative or positive**

T or Tdap (Required within ten years of admission) Date: _____

MMR Date: _____ Date: _____ or Titer Report: _____

Varicella (Chicken Pox) Date: _____ Date: _____ or Titer Report: _____

(*Must have two vaccine dates or positive IgG report attached; history of having disease is not acceptable)

Menactra (Meningitis) Date: _____ (Not required for commuters)

RECOMMENDED: (For students who will possibly be exposed to blood and/or body fluids in a clinical and/or research setting)

Hepatitis B: Dose 1: _____ Dose 2: _____ Dose 3: _____

Polio: Date Series Completed: _____ Date of last booster: _____

Gardasil: Dose 1: _____ Dose 2: _____ Dose 3: _____

Influenza: Last dose received: _____

URINALYSIS/URINE DIP STICK: Glucose: _____ Ketones: _____ pH: _____

Leukocytes: _____ Nitrites: _____ Blood: _____

If Indicated (Serum): Hgb/Hct: _____ Glucose: _____ Na+: _____ K+: _____

Are there any abnormalities of the following? (Use additional sheet of paper for positive answers)	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?		

Current Medications: _____ Physical Restrictions: _____

Do you have any recommendations regarding the care of this student? _____

Is the student currently under treatment for any medical or emotional condition? _____

Physician's Signature: _____ Date: _____

Address: _____

Print Last Name: _____

Return completed forms to:
 Lincoln University Health Services
 Wellness Center, Suite 100
 1570 Baltimore Pike
 Lincoln University, PA 19352-0999
 Ofc: 484-365-7338 Fax: 484-365-7287

Lincoln University
Health Screening ~ Risk Assessment
 Supplement Form (S1) ~ to be completed by ALL students

The following information is required for all students seeking admission to Lincoln University and/or residence on Lincoln University Campus. This information **MUST** be reviewed and signed by a licensed professional (Physician/Nurse Practitioner) prior to the individual's arrival on campus.

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Student ID Number _____

Please answer all of the following questions (If yes, please provide details on separate sheet of paper)

	Yes	No
1. Have you been in contact with anyone who has been diagnosed with the Ebola Virus?		
2. Have you been a caregiver for anyone exhibiting symptoms of the Ebola Virus? (Sudden onset of fever fatigue, muscle pain, headache and sore throat. This is followed by vomiting, diarrhea, rash, symptoms of impaired kidney and liver function, and in some cases, both internal and external bleeding (e.g. oozing from the gums, blood in the stools)		
3. Have you exhibited and/or been treated for any symptoms of the Ebola Virus in the past 90 days?		
4. Have you taken part in any ritualistic funeral ceremonies and/or handled any human remains or personal effects of any person infected with the Ebola Virus?		
5. Have you been in contact with any fruit bats of the Pteropodidae family, with the blood, secretions, organs or other bodily fluids of infected animals such as chimpanzees, gorillas, fruit bats, monkeys, forest antelope and porcupines found ill or dead or in the rainforest?		
6. Have you consumed any raw meat from any of the above wildlife?		
7. Have you traveled to or from Sierra-Leone, Guinea, Liberia, Nigeria, or Senegal within the past 90 days?		
8. Have you been in contact with anyone who has traveled to or from Sierra-Leone, Guinea, Liberia, Nigeria, or Senegal within the past 90 days?		

Student's Signature _____
 (If student is a minor parent/guardian signature is required)

Date _____

Reviewing Physician's Signature _____

Date _____

Print Name _____

Address _____

Telephone Number _____