**LINCOLN UNIVERSITY HEALTH SERVICES**

**PHYSICAL EXAMINATION FORM**

To The Student: All following students are required to file this physical examination form in order to complete registration.

* All incoming freshman, transfer students, and re-admit students
* Annually by all participants, men and women, in Intercollegiate Athletic Programs, as requested
* 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.

This information is strictly for Health Services use and will not be released without your knowledge and consent.

**\*\*MANDATORY – All entering students must fill out this report of medical history**

**PLEASE COMPLETE THIS PAGE BEFORE GOING TO YOUR PHYSICIAN FOR YOUR EXAMINATION**

**LAST NAME (PLEASE PRINT LEGIBLY) FIRST NAME MIDDLE INITIAL LAST 4 DIGITS OF SSN GENDER**

**HOME ADDRESS CITY OR TOWN STATE ZIP CODE DATE OF BIRTH**

**STUDENT’S CELL PHONE NUMBER STUDEDNT’S HOME PHONE NUMBER YEAR ENTERING LINCOLN UNIVERSITY FALL OR SPRING**

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

Does your religion prohibit any type of treatment? YES NO

FAMILY HISTORY HAVE ANY OF YOUR RELATIVES EVER HAD ANY OF THE FOLLOWING?

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 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  Bro/Sis |  |  |  |  |  |  |  |  |  |  | Epilepsy, 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 |  |  | Frequent Anxiety |  |  | Chronic Cough |  |  | Recurrent Diarrhea |  |  |
| German Measles |  |  | 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 |  |  |
|  |  |  | **Seasonal Allergies** |  |  | **Sulfonamides** |  |  | Nuva Ring |  |  |
| **Food Allergies** |  |  | 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 THE PERSONAL HEALTH HISTORY) DATE**

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**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) Year Entering \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fall \_\_\_\_\_\_\_\_\_ Spring \_\_\_\_\_\_\_\_\_**

**URINALYSIS: Glucose: \_\_\_\_\_\_\_\_\_ Ketones: \_\_\_\_\_\_\_ pH: \_\_\_\_\_\_\_\_\_ Specific Gravity \_\_\_\_\_\_\_\_\_\_\_ Leukocytes: \_\_\_\_\_\_\_\_\_\_\_**

**Nitrites: \_\_\_\_\_\_\_\_\_\_\_\_ Blood: \_\_\_\_\_\_\_\_\_**

**If Indicated (Serum): Hgb/Hct: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Glucose: \_\_\_\_\_\_\_\_ Na+: \_\_\_\_\_\_\_\_\_\_\_ K+: \_\_\_\_\_\_\_\_\_\_\_ BUN/Creat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **ARE THERE ANY ABNORMALITIES OF THE FOLLOWING? (Use additional sheet of paper for positive answers)** | **Yes** | **No** |
| 1. **Head, Ears, Nose, or Throat** |  |  |
| 1. **Respiratory** |  |  |
| 1. **Cardiovascular** |  |  |
| 1. **Gastrointestinal** |  |  |
| 1. **Hernia** |  |  |
| 1. **Eyes** |  |  |
| 1. **Genitourinary** |  |  |
| 1. **Musculoskeletal** |  |  |
| 1. **Metabolic/Endocrine** |  |  |
| 1. **Neuropsychiatric** |  |  |
| 1. **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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **RECORD OF IMMUNIZATIONS (Required for ALL incoming students)** | **DATE** | **DATE** |
| **HAVE YOU EVER RECEIVED BCG VACCINE? YES NO**  **(IF APPLICABLE) DATE BCG VACCINE RECEIVED** |  | **██** |
| **TUBERCULOSIS (Must Be Within 1 Year of Admission)**  **Reading: mm Induration**  **(Please Attach Copy Of CXR Report If Applicable)** | **Date Given** | **Date Read** |
| **TETANUS (TDAP) Must Be Within 10 Years of Admission** |  |  |
| **MMR (Must Show Two Dates Or Attach Titer Report)** |  |  |
| **VARICELLA (Must Show Two Dates Or Attach Titer Report)** |  |  |
| **MENACTRA (Not Required For Commuters)** |  |  |

**Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Return this information to:**

**Lincoln University Health Services**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wellness Center, Suite 100**

**1570 Baltimore Pike**

**Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lincoln University, PA 19352-0999**

**Ofc: 484-365-7338 Fax: 484-365-7287**

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**LINCOLN UNIVERSITY**

**Health Screening ~ Risk Assessment**

**Supplement Form (S1) ~ to be completed by all International Students**

The following information is required for all International Students seeking admission to Lincoln University and/or residence on Lincoln University Campus. This information must be reviewed and signed by a licensed physician prior to the individual’s arrival on campus.

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial \_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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? |  |  |
| 1. 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) |  |  |
| 1. Have you exhibited and/or been treated for any symptoms of the Ebola Virus in the past 90 days? |  |  |
| 1. 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? |  |  |
| 1. 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? |  |  |
| 1. Have you consumed any raw meat from any of the above wildlife? |  |  |
| 1. Have you traveled to or from Sierra-Leone, Guinea, Liberia, Nigeria, or Senegal within the past 90 days? |  |  |
| 1. 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reviewing Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Revised 02/ 2015**

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**INFORMED CONSENT FOR TREATMENT OF MINORS**

The Office of Health Services at Lincoln University has medical professionals on staff Monday thru Friday 9:00am to 4:00pm to evaluate and treat faculty, staff, and students for routing and emergent medical conditions. Minor students who attend classes and/or programs on Lincoln University Campus require parental/guardian consent for treatment. A notice of Privacy Practices is provided to all students in accordance with the Health Insurance Portability and Accountability Act (HIPPA) of 1996.

Please complete and sign the following form, and return it to the attention of the Health Services Office along with a current health history, immunization history, and physical examination signed by your primary care physician or another licensed health care practitioner.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please print), the Parent/Guardian of

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please print), do hereby give my consent to the medical professionals on staff at Lincoln University to evaluate and treat my minor child. I understand that by providing this consent, I am releasing Lincoln University and its’ professional staff from liability, acknowledging that said treatment is being provided as a courtesy to my child. Treatment may include, but not be limited to, the administration of medications, as well as referrals to Jennersville Regional Hospital and/or medical professionals on staff at Jennersville Regional Hospital.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Minor Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Office of Health Services (Wellness Center, Suite 100) 1570 Baltimore Pike Lincoln University, PA 19352