Physical Examination *(to be completed by your health care provider)*

Please review the student's health history and complete this form, commenting on all positive answers. This student has been accepted at Geneva College and the information supplied will not affect student's status. It will be used as a background for providing health care, if necessary. This information is strictly for the use of Health and Counseling Services and will not be released without the student's written consent.

Name of Student: _____ Date of Birth: _____

Date of Physical: _____ (examined within one year prior to coming to campus)

Blood Pressure: _____ Weight:_____ Height:_____ Sex:_____

Are there abnormalities in the following systems? Describe fully. Use additional sheet if necessary. Check each item in the appropriate column.

	Normal	Abnormal	Detail of each abnormality
Head, neck, face and scalp			
Nose and sinuses			
Mouth, teeth, gingiva and throat			
Ears – General (canals, drums, etc.)			
Eyes – General (lids, pupils, motions)			
Lungs, chest and breasts			
Heart			
Vascular system (including varicosities)			
Abdomen and viscera (including hernia)			
Ano-Rectal and pilonidal			
Endocrine system			
Genito-urinary system			
Upper extremities			
Lower extremities (including feet)			
Spine, other musculo-skeletal			
Skin and lymphatics			
Neurological system			
Psychiatric (personality deviation)			
If female, give menstrual history			

Is there loss or seriously impaired function of any organ? ☐ YES ☐ NO

Recommendation for physical activity (PE, competitive sports, intramurals) ☐ Unlimited ☐ Limited

If there are limitations, explain: _____

Is patient under treatment or on any medication for any medical or emotional condition? Do you have any recommendations regarding the care of this student?

_____

_____

_____

Urinalysis (if deemed necessary by health care provider completing this form):

Date:_____ Sugar_____ Albumin_____ Micro_____ Hb. Or Hct._____

***Recommended Immunizations* – Complete to the best of your ability, if you have not received the vaccine then please leave that spot blank. Please be aware that you may be asked to leave campus if there is an outbreak of a certain virus of which you have not been immunized. You will also be asked to reiterate this information on the Immunization History form.**

Tetanus/Diphtheria – must have received a primary series of DTP, DT or Td and a booster within past 10 years.
Measles, Rubella, Mumps – proof of vaccination or a titer is acceptable, primary injection with a booster.
Polio- primary series in childhood
Varicella – either a history of chicken pox, Varicella antibody or two (2) doses of vaccine given at least one month apart if immunized after age 13, or one (1) dose of vaccine if immunized before age 12.
Hepatitis B – series of three (3) injections given at specific time intervals.
Meningococcal – One (1) dose, preferably at entry to college for freshman living in residence halls that wish to reduce their risk of meningococcal disease. Any undergraduate less than 25 years of age who wishes to reduce their risk can consider this vaccine. Students with immunodeficiency, such as complement deficiency or asplenia, should receive vaccine q. 3-5 years. All students that are residing in college or university-owned housing are required to have at least one (1) dose of the meningococcal vaccine or a signed waiver declining the vaccine after being given literature on the vaccine and the disease.

Additional Recommended Immunizations
Influenza – annual immunization to avoid disruption to academic activities. These are given late fall providing they are not contradicted due to medical history or allergies.
COVID-19 – There will be an additional form that student will be required to complete if they received a COVID-19 vaccine within the Student Health Portal.

Updated Immunizations Recommended for Admission

	DATES	BOOSTERS
Diphtheria		
Pertussis		
Tetanus (within 10 years)		
Polio		
Measles		
Rubella		
Mumps		
Varicella		
Hepatitis B		
Meningococcal Vaccine		

Tuberculosis Screening, if student is at risk (if positive, please list follow-up given)

☐ Negative ☐ Positive Date: _____

Healthcare provider's signature:_____

Print health care provider name: _____

Address:_____