

Pre-Matriculation Physical Evaluation

February, 2009

Dear Doctor:

Please complete the attached pre-matriculation physical evaluation and perform a physical examination for our incoming student. The following is a list of **REQUIREMENTS** that must accompany this form. Please contact our office at (215) 955-6835 if you have questions. A copy of the results for all titers must accompany the form.

Requirements:

1. Measles Immunity as documented by a positive IgG antibody titer (**copy must be attached**).
2. Mumps Immunity as documented by a positive IgG antibody titer (**copy must be attached**).
3. Rubella Immunity as documented by a positive IgG antibody titer (**copy must be attached**).
4. Varicella Immunity as documented by:
 - a. Positive IgG antibody titer (**copy must be attached**);
 - b. **OR**, Proof of 2 vaccines
5. Tetanus/Pertussis Immunity as documented by a recent dose of the acellular pertussis/diphtheria/tetanus booster (Tdap or Adacel)
6. Hepatitis B Immunity as documented by:
 - a. 3 doses of the vaccine **and** a positive hepatitis B surface antibody
 - b. **OR**, a signed declination form (available in our office)
7. Tuberculosis Screening
 - a. If negative PPD history, a two-step PPD is **REQUIRED** during the present calendar year.
 - i. Definition: a two-step PPD is 2 PPD's placed 1-3 weeks apart.
 - b. If positive PPD history, a copy of a chest x-ray report done within the past 6 months is required.
8. Meningitis Vaccination
 - a. Only students **planning to reside in Jefferson housing** must consider this vaccine. These students must provide the date of vaccination or provide the signed waiver form available on this website.

Sincerely,

Ellen M. O'Connor, MD
Medical Director, University Health Services

Pre-Matriculation Physical Evaluation

| | | | | | | | |
|--|--|-------|-----|---|--|-------|-----|
| Name (Last/First) | | | | Date of Birth | | Sex | |
| Current Address | | | | Local Address | | | |
| City | | State | Zip | City | | State | Zip |
| Home Telephone | | | | SS# | | | |
| Cell Phone Number | | | | Jefferson E-mail Address | | | |
| In case of an emergency contact (name, phone): | | | | | | | |
| Previous Jefferson Student? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, give program and year of graduation) | | | | Previous Jefferson Employee? <input type="checkbox"/> No <input type="checkbox"/> Yes | | | |
| | | | | Employment Termination Date: ____/____/____ | | | |

Program you are entering (please include Program on all correspondence)

| Program | Start Date | Expected Graduation Date | Program | Start Date | Expected Graduation Date |
|--|------------|--------------------------|---|------------|--------------------------|
| <input type="checkbox"/> School of Health Professions | | | <input type="checkbox"/> Graduate Programs | | |
| <input type="checkbox"/> Bioscience Technologies | | | <input type="checkbox"/> MSN | | |
| <input type="checkbox"/> Couple and Family Therapy | | | <input type="checkbox"/> Community Systems Admin | | |
| <input type="checkbox"/> Occupational Therapy | | | <input type="checkbox"/> Advanced Practice Nurse (NP & CNS) | | |
| <input type="checkbox"/> Transitional Doctorate of Physical Therapy | | | <input type="checkbox"/> Nursing Informatics | | |
| <input type="checkbox"/> Radiologic Sciences | | | <input type="checkbox"/> Nurse Anesthetist | | |
| <input type="checkbox"/> Doctorate of Physical Therapy | | | <input type="checkbox"/> Minor in Nursing Education | | |
| <input type="checkbox"/> School of Pharmacy | | | <input type="checkbox"/> Post-MSN Certificates | | |
| <input type="checkbox"/> Jefferson College of Graduate Studies | | | <input type="checkbox"/> Doctor of Nursing Practice (DNP) | | |
| <input type="checkbox"/> PhD | | | <p style="text-align: center;">VERIFICATION OF INFORMATION</p> <p>The following statements are true to the best of my knowledge. I understand that any false statement made purposely may be grounds for dismissal from the program.</p> <p style="text-align: center;">STATEMENT OF CONFIDENTIALITY</p> <p>All medical records within University Health Services are confidential and will not be released without written authorization from the student. For infection control purposes, I give my permission to have ONLY my immunization and/or tuberculosis screening information forwarded for future participation in affiliate programs. This permission is in effect until I graduate from Jefferson or leave my program. I am aware that I may revoke this permission at any time.</p> <p style="text-align: center;"> <input checked="" type="checkbox"/> _____ Signature Date </p> | | |
| <input type="checkbox"/> MS Basic Science | | | | | |
| <input type="checkbox"/> Master of Public Health | | | | | |
| <input type="checkbox"/> Jefferson Medical College | | | | | |
| <input type="checkbox"/> Jefferson School of Nursing Undergraduate Programs | | | | | |
| <input type="checkbox"/> ASN-BSN | | | | | |
| <input type="checkbox"/> BSN | | | | | |
| <input type="checkbox"/> Accelerated Pathway to MSN for 2nd-Degree Non-Nurses | | | | | |
| <input type="checkbox"/> FACT (BSN in 1 calendar year; MSN in 1 additional year) | | | | | |
| <input type="checkbox"/> Programs for RNS | | | | | |
| <input type="checkbox"/> RN-BSN (in class) | | | | | |
| <input type="checkbox"/> RN-BSN (online) | | | | | |
| <input type="checkbox"/> RN-BSN/MSN | | | | | |
| <input type="checkbox"/> Accelerated Pathway to MSN for 2nd-Degree RNS | | | | | |
| <input type="checkbox"/> School of Population Health | | | | | |

Pre-Matriculation Physical Evaluation

| | |
|--------------|-----------------|
| Name (Print) | Date of Birth |
| Program | Graduation Year |

Medical History: Do you have, or have you ever had any of the problems listed below? (please check)

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Angina | <input type="checkbox"/> Stroke | <input type="checkbox"/> Gall bladder disease | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Persistent dizziness | <input type="checkbox"/> Ulcer disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Coughing of blood | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Persistent headache | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Leg swelling | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Vomiting blood | <input type="checkbox"/> Undue fatigue |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Persistent diarrhea | <input type="checkbox"/> Excessive weight gain |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive weight loss |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Back trouble | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Pain down leg | <input type="checkbox"/> Cancer | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Difficulty with urination | <input type="checkbox"/> Numbness down leg | <input type="checkbox"/> Visual difficulty | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Hearing difficulty | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> Heart attack | | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Skin rash | |

Do you have any medical problems not listed above? Yes No
Please list specific problems:

Please list all surgical procedures:

| Date | Procedure |
|------|-----------|
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Do you have allergies to medicine? Yes No
If yes, please list (include penicillin, sulfa drugs, tetracycline, etc.):

Do you have a sensitivity to latex? Yes No
If yes, please explain workup:

Do you have any physical, medical, or emotional problems that you think may warrant special arrangements at school? Yes No
Comments:

Have you ever been hospitalized for any medical condition?
 Yes No

| If yes: Month(s)/Year(s) | Reasons |
|--------------------------|---------|
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| | |
| | |
| | |

Do you take medication regularly? Yes No
If yes, please list (include vitamins, herbal supplements, birth control pills, etc.):

Do you smoke? Yes No
If yes, how many cigarettes per day? _____ /day
If no, have you ever smoked? _____

Do you drink alcohol? Yes No
If yes, amount: _____

Do you have a history of alcohol or substance abuse? Yes No
If yes, explain:

Do you have any medical complaints now? Yes No
Comments:

Pre-Matriculation Physical Evaluation

Physical Examination

| | | | |
|--------------|-------|----|-----------------|
| Name (Print) | | | Date of Birth |
| Program | | | Graduation Year |
| BP | Pulse | Ht | Wt lb. |

| | Normal | Abnormal | Not Examined | Remarks |
|----------------|--------|----------|--------------|---------|
| General Health | | | | |
| Skin | | | | |
| Ears | | | | |
| EOMS | | | | |
| Pupils | | | | |
| Fundi | | | | |
| Nose/Mouth | | | | |
| Carotids | | | | |
| Thyroid | | | | |
| Lymph Nodes | | | | |
| Lungs | | | | |
| Heart | | | | |
| Abdomen | | | | |
| Extremities | | | | |
| Cranial Nerves | | | | |
| Motor | | | | |
| Sensory | | | | |
| Reflexes | | | | |
| | | | | |
| | | | | |

| | | | |
|-----------|-----|-----|------------------------|
| Vision | OD: | OS: | Color Blindness Screen |
| Corrected | OD: | OS: | Date of Last Eye Exam |

Referrals, risk factors, comments, etc.:

| | |
|-------------------|--------------|
| MD/CRNP Signature | Printed Name |
| Phone # | Address |