Pre-Matriculation Physical Evaluation Form

Dear Provider :

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. ***A copy of the results for all titers must accompany the form.*** Please contact our office at 215-951-2986 if you have questions.

Requirements:

1. Measles Immunity as documented by a positive IgG antibody titer **(copy must be attached).**
   a. If negative titer result for Measles, documentation of two MMR vaccines is needed (initial MMR series acceptable).

2. Mumps Immunity as documented by a positive IgG antibody titer **(copy must be attached).**
   a. If negative titer result for Mumps, documentation of two MMR vaccines is needed (initial MMR series acceptable).

3. Rubella Immunity as documented by a positive IgG antibody titer **(copy must be attached).**
   a. If negative titer result for Rubella, documentation of one MMR vaccine is needed (initial MMR series acceptable).

4. Varicella Immunity as documented by **2** Varicella vaccines **OR** positive IgG antibody titer **(copy must be attached).**

5. Tetanus/Diphtheria/Pertussis Immunity as documented by:
   a. A recent dose of the Tdap (tetanus/diphtheria/acellular pertussis) booster, recommended within 5 years of your start date. Common brand names are Adacel and Boostrix. Tetanus/Td will **NOT** be accepted.

6. Hepatitis B Immunity as documented by:
   a. 3 doses of the vaccine **and** a positive **Quantitative** Hepatitis B Surface Antibody
   b. If negative, receive 4th dose of the Hep B vaccine, repeat titer four weeks from the 4th dose.
   c. If repeat titer is positive, no further testing is needed.
   d. If repeat titer is negative, continue with doses 5 & 6 as scheduled.
   e. If Hep B Surface Antibody is negative after a secondary series (total of 6 doses), additional testing including Hep B Surface Antigen & Hep B Core Antibody should be performed.

7. Tuberculosis Screening
   a. IGRA Blood Test (Interferon Gamma Release Assay) is the required test, regardless of prior BCG status. To be performed within 3 months prior to the start of your first semester. Common brand names are Quantiferon-TB Gold and T-SPOT **(copy of lab report must be attached).** PPD will **NOT** be accepted
   b. If positive history along with INH treatment, 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 Philadelphia University housing are required by Pennsylvania State Law to consider** this vaccine. These students must provide the date of vaccination or provide the signed waiver form available on our website.

9. Seasonal influenza vaccine is mandatory
   a. If received outside of UHS, documentation is required. Include the following: date of vaccination, manufacturer, lot number, expiration date, signature of administrator.

Pre-Matriculation Physical Evaluation Form

Last Name:		First Name:	
Date of Birth: / /	Sex: M F FtM MtF	Campus key:	Year entering:
Current Address:			
City:		State:	Zip:
Local Address:			
City:		State:	Zip:
Home Telephone: ( )		Cell Phone Number: ( )	
Jefferson E-mail Address:		@students.jefferson.edu	
In case of an emergency contact - Name		Emergency Contact - Phone ( )	
Previous Jefferson Student? (If yes, give program and year of graduation) No Yes			

VERIFICATION OF INFORMATION

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.

STATEMENT OF CONFIDENTIALITY

All medical records within Philadelphia University Student 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.

HEALTH INSURANCE INFORMATION: Please attach a copy of the front and back of your current Health Insurance Card. The online insurance waiver *must be completed* unless you desire to purchase the University-sponsored insurance plan. For more information, check the school's STUDENT ACCOUNTS webpage and BANNER.

CONSENT FOR TREATMENT/INFORMATION RELEASE

The undersigned herewith:

A. Grants permission to Thomas Jefferson University Student Health Services to provide medical care including administration of treatments and medications as necessary. This includes emergency room visits, lab work, x-rays, etc., which may need to be done at local facilities including local emergency departments, hospitals and medical practices, local imaging and lab locations.

B. Authorizes Thomas Jefferson University Student Health Services, Disabilities Services and/or Athletic Trainers/Sports Medicine Services to exchange and release information to each other that may affect my athletic participation. Understands that this information includes but is not limited to this pre-season questionnaire/screening and Jefferson (Philadelphia University + Thomas Jefferson University) Student Health Services health evaluation, immunization record, consent for treatment and questionnaire.

Thomas Jefferson University Student Health Services health evaluation, immunization record, consent for treatment and questionnaire

Signature _____ Date _____

Signature of parent/guardian if under 18 _____ Date _____

PROGRAMS/DEGREE	Start Date	Expected Graduation Date

Pre-Matriculation Physical Evaluation Form

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 circle)*

Asthma
Wheezing
Chronic Cough
Coughing of blood
Shortness of breath
Pneumonia
Emphysema
Tuberculosis
High Blood pressure
Rheumatic fever Heart murmur
Heart attack

Chest pain
Angina
Night Sweats
Palpitations
Leg swelling
Phlebitis
Kidney stones
Blood in urine
Urinary tract infection
Difficulty with urination
Sexually transmitted infection

Syphilis
Stroke
Persistent dizziness
Persistent headache
Seizure disorder
Loss of consciousness
Paralysis
Back trouble
Pain down leg
Numbness down leg
Abdominal pain
Hepatitis

Jaundice
Gall bladder disease
Ulcer disease
Blood in stool
Vomiting blood
Persistent diarrhea
Anemia
Bleeding
Cancer
Visual difficulty
Hearing difficulty
Skin rash

Arthritis
Gout
Thyroid disease
Diabetes
Undue fatigue
Excessive weight gain
Excessive weight loss
Depression
Anxiety
Eating Disorder
ADHD
Bipolar Disorder

Do you have any medical problems not listed above? Y N

Please list specific problems:

Please list all surgical procedures:

Date	Procedure

Do you have allergies to medicine? Y N

If yes, please list (include penicillin, sulfa drugs, tetracycline, etc.) and include reaction:

Do you have a sensitivity to latex? Y N

If yes, please explain workup:

Do you have any physical, medical, or emotional problems that you think may warrant special arrangements at school?
Y N

Comments:

Have you ever been hospitalized for any medical condition?

Y N

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

Do you take medications regularly? Y N

If yes, please list (include vitamins, herbal supplements, birth control pills, etc.)

Do you smoke? Y N

If yes, how many cigarettes per day? / day

If no, have you ever smoked?

Do you drink alcohol? Y N

If yes, amount:

Do you have a history of alcohol or substance abuse? Y N

If yes, explain:

Do you have any medical complaints now? Y N

Comments:

Pre-Matriculation Physical Evaluation Form

Name (Print)	Date of Birth / /
Program	Graduation Year

Student Immunization Documentation

The following information is required prior to starting at Thomas Jefferson University.
To be filled out by Physician, Nurse Practitioner or Physician Assistant

MMR (Measles, Mumps, Rubella)		**please circle:**
Measles (Rubeola)	Measles/Rubeola (IgG), antibodies, titer Date: / /	Results: POS NEG EQUIV **Lab Report Attached**
Mumps	Mumps (IgG), antibodies, titer Date: / /	Results: POS NEG EQUIV **Lab Report Attached**
Rubella	Rubella (IgG), antibodies, titer Date: / /	Results: POS NEG EQUIV **Lab Report Attached**

Varicella (Chicken Pox)			
	Dose #1 Date: / / Dose #2 Date: / /	**OR**	Varicella (IgG), antibodies, titer Date: / / Results: POS NEG EQUIV **Lab Report Attached**

Tetanus/Diphtheria/Pertussis (TDAP) - Recommended within 5 years of your start date.
Vaccine Date: / /

Hepatitis B Immunity - LAB REPORT MUST BE ATTACHED			
Primary Hepatitis B Series	Dose #1 Date: / / Dose #2 Date: / / Dose #2 Date: / /	**Secondary Hepatitis B Series** (If no response to primary series)	Dose #4 Date: / / Dose #5 Date: / / Dose #6 Date: / /
QUANTITATIVE Hep B Surface Antibody Date: / / Results: mIU/ml D **Lab Report Attached**		**QUANTITATIVE** Hep B Surface Antibody Date: / / Results: mIU/ml **Lab Report Attached**	
Hepatitis B Vaccine Non-responder (If Negative Hep B surface Antibody after Primary & Secondary Series	Hepatitis B Surface Antigen (If negative 2nd titer) Date: / / Results: **Lab Report Attached**		
	Hepatitis B Core Antibody (If negative 2nd titer) Date: / / Results: **Lab Report Attached**		
Chronic Active Hepatitis B	Hepatitis B Surface Antigen Date: / / Results: **Lab Report Attached**		
	Hepatitis B Viral Load Date: / / Results: **Lab Report Attached**		

Tuberculosis Screening - IGRA Blood Test (Interferon Gamma Release Assay) - LAB REPORT MUST BE ATTACHED			
To be performed within 3 months prior to the start of your first semester			
IGRA Blood Test (Interferon Gamma Release Assay	Date: / /	Results: _____	**Lab Report Attached**
Positive History Only: Chest x-ray within 6 months required for all positive results			
Chest X-ray	Date: / /	Results: _____	**Chest X-ray Report Attached**

Meningitis Vaccination - Only students planning to reside in Jefferson housing must consider this vaccine.	
Living in Jefferson Housing Yes No	Date of vaccine (If answered yes)_____OR Date of declination _____

Influenza - Vaccination is required for students. Fall incoming students will receive in September.	
Vaccine Date: / /	man/lot/exp:

MD/CRNP/PA-C Signature	Date
Printed Name	Phone # ( )
Address	

Pre-Matriculation Physical Evaluation Form

Name (Print)	Date of Birth / /
Program	Graduation Year

Physical Examination

BP /	Pulse	Ht ft. in.	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				
Nursing / OT / PT Students ONLY (Back Exam)				
Back Exam				
Range of Motion				
Flexibility				

Vision: OD OS **Color Blindness Screen:** Normal Abnormal_____# plates of _____

Corrected: OD OS **Date of Last Eye Exam:**

To the best of my knowledge, based on my exam today, I believe this patient is (please circle)**:**

fit to be a student

fit to be a student with the following restriction:_____

not cleared

MD/CRNP/PA-C Signature	Date:
Printed Name:	Phone #: ( )
Address:	

Please list anything else you feel we need to know:

PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR CURRENT HEALTH INSURANCE CARD: