PHYSICAL EXAM

HEALTH SERVICES
401-232-6220 FAX- 401-232-6702

STUDENT'S NAME: _____ **DATE OF BIRTH:**_____
STUDENT ID #: _____
Date of Exam: _____ **(MUST be within one year of University entry - - six months for athletes)**

- VITALS MUST BE COMPLETED

Blood Pressure: _____ **Pulse:** _____ **Height (inches):**_____ **Weight (lbs):**_____**BMI:** _____

NORMAL	Check each item in appropriate column Enter NE if not evaluated	NOTE: Describe every abnormality in detail
	Head, face, neck, scalp	
	Nose and sinuses	
	Mouth, teeth, throat	
	Ears	
	Eyes	
	Ophthalmoscopic	
	Neck, thyroid	
	Thorax and breasts	
	Lungs	
	Heart	
	Abdomen	
	Anus and rectum	
	Endocrine system	
	G.U. system	
	Upper extremities	
	Lower extremities	
	Feet	
	Spine	
	Neurologic	
	Psychiatric evaluation	
	Skin	
	Lymphatic system	
	Vascular system	
	Other:	

Is this student receiving or does he/she require continuing medical care, therapy or observation? _____
If **YES**, please explain (include notation of medication and dosages and plans concerning illness such as heart disease, asthma, diabetes, seizure disorders, etc.) _____

_____

_____

- **Does this student have any life-threatening allergies? YES ____ NO _____**

_____ (If yes, please send allergic response and suggested treatment)

I hereby declare that the above named student is medically cleared to participate in intercollegiate athletics at Bryant University.
Fit to participate **YES** ____ **NO** _____

HEALTH CARE PROVIDER:

Print Name: _____ Phone: _____
Address: _____
Signature: _____ Date: _____

IMMUNIZATION RECORD

HEALTH SERVICES
401-232-6220 FAX- 401-232-6702

*** To be completed and signed by health care provider ***

STUDENT'S NAME: _____ **DOB:** _____

STUDENT ID #: _____

REQUIRED IMMUNIZATIONS (prior to matriculation)

All information must be in English (dates must include month, day and year)

A. TETANUS, DIPTHERIA, PERTUSSIS (MUST be within 10 years)

Tdap _____/_____/_____ **(preferred booster)** **OR** Td _____/_____/_____

B. MMR (MEASLES, MUMPS, RUBELLA) - 2 doses required

Dose 1 given at age 12 months or later - - Dose 2 given at least 28 days after first dose

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____

OR

1. **MEASLES (Rubeola)** positive immune titer date _____/_____/_____
2. **RUBELLA (German measles**) positive immune titer date _____/_____/_____
3. **MUMPS** positive immune titer date _____/_____/_____

C. HEPATITIS B - 3 doses required

1. Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____

OR

2. Adult Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ (only if given from ages 11-15)

OR

3. Hepatitis B titer Reactive_____ Non-reactive_____ Date _____/_____/_____

OR

4. Combined Hepatitis A and B Dose#1____/_____/____ Dose #2____/____/____ Dose#3____/____/____

D. VARICELLA (Chickenpox) - 2 doses required

1. History of chickenpox disease Yes_____ Date ____/_____/_____

OR

2. Dose #1 _____/_____/_____ Dose #2 _____/_____/_____

OR

3. Varicella titer Date ____/_____/_____ Reactive_____ Non-reactive _____

*** REQUIRED for all first-year athletes ONLY**

RECOMMENDED IMMUNIZATIONS

E. MENNINGOCOCCAL QUADRIVALENT (Meningitis) - 2 doses, if dose 1 given before age 16
(A, C, Y, W-135) - Conjugate (MCV4) - Preferred (menactra)

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____

(A, C, Y, W-135) - Polysaccharide - Acceptable (menomune)

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____

F. HUMAN PAPILLOMAVIRUS (HPV) - 3 doses (HPV4_____ or HPV2_____)

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____

G. HEPATITIS A – 2 doses

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____

H. INFLUENZA

Date of last dose _____/_____/_____

I. TUBERCULOSIS (TB) SCREENING/TESTING

Have you ever had a positive TB skin test? Yes _____ No _____

Have you ever had close contact with anyone who was sick with TB? Yes _____ No _____

Were you born outside of the US and arrived in the U.S. within the past 5 years? Yes _____ No _____
(If yes, must prove testing below)

Have you ever been vaccinated with BCG? Yes _____ No _____

Tuberculin Skin Test

Date planted _____/_____/_____ Date read _____/_____/_____

Result _____mm NEG _____ POS _____

OR

IGRA (Interferon Gamma Release Assay) Date _____/_____/_____ method QFT-G ___QFT-GIT___T-spot____

Result NEG _____ POS _____ Intermediate _____

OR

Chest x-ray (required if either test is a **positive result)**

NEG _____ POS_____ Date _____/_____/_____

HEALTH CARE PROVIDER:

Print Name: _____ Phone: _____

Signature: _____ Date: _____