



MEDICAL EXAMINATION

To be completed in full.

EDUCATING REFLECTIVE, PRINCIPLED, AND CREATIVE LEARNERS
IN THE TRADITION OF THE SISTERS OF ST. JOSEPH

291 SPRINGFIELD STREET • CHICOPEE, MA 01013-2839 • 413-594-2761 • WWW.ELMS.EDU

To the examining clinician: Please review the student's history and complete the physicians form. Please comment on all positive answers. *This student has been accepted.* The information supplied will not affect his/her status: it will be used as background for providing health care, if necessary. Information is strictly for use by Health Services and will not be released without student consent.

Last Name (surname) _____ First Name _____ Middle Name _____

Student I.D. Number _____

Date of Birth (mo/day/yr) _____ Height _____ Weight _____ Blood pressure _____ Pulse _____

IMMUNIZATION HISTORY (circle dose type and indicate date given. This information is required.)

Varicella Vaccine	DTP/DI/TD/T	DTP/DI/TD/T	DTP/DI/TD/T	Hepatitis B Vaccine	Measles	Mumps	Rubella	MMR
mo/day/yr	mo/day/yr	mo/day/yr	mo/day/yr	mo/day/yr	mo/day/yr	mo/day/yr	mo/day/yr	
#1 _____				#1 _____	#1 _____	#1 _____	#1 _____	#1 _____
#2 _____				#2 _____	#2 _____			#2 _____
				#3 _____				
T.B Skin Test (within last 12 mo.) (Mantoux) <i>Required for all full and part time nursing majors only*</i>					Tdap if last dose more than 10 years, booster required			
Date _____ Result _____					mo/day/yr			

***Recommended Meningitis Vaccine:** (date and type of vaccine) _____ or enclosed signed waiver

Are there any abnormalities of the following:

- | | | | | | |
|----------------------------------|---|---|-------------------------|---|---|
| 1. skin, blood | Y | N | 6. hernia | Y | N |
| 2. eyes, head, ear, nose, throat | Y | N | 7. genitourinary | Y | N |
| 3. respiratory | Y | N | 8. musculoskeletal | Y | N |
| 4. cardiovascular | Y | N | 9. metabolic/endocrine | Y | N |
| 5. gastrointestinal | Y | N | 10. neurologic/seizures | Y | N |

If "yes" to any of the above explain _____

Allergies _____

* Required for all participants on athletic teams:	Femoral pulse (indicate 1-4+) R _____ L _____
	Apical heart rate Lying _____ Sitting _____
Urinalysis _____ HGB or HCT _____	

Clinician signature _____ Date of exam _____

Clinician address _____ Telephone _____