ELMS COLLEGE

MEDICAL EXAMINATION
To be completed in full

291 SPRINGFIELD STREET • CHICOPEE, MA 01013-2839 • 413-594-2761 • WWW.ELMS.EDU
HEALTH CENTER (PHONE) 413-265-2288 • (FAX) 413-592-9939

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 *(2 required)*	**Hepatitis B Vaccine** *(3 required)*	**MMR** *(2 required)*	**Tdap** *(within 10 years)*
mo/day/yr #1_____ #2_____ OR positive Titer Date:_____	mo/day/yr #1_____ #2_____ #3_____ OR positive Titer Date:_____	mo/day/yr #1_____ #2_____ OR positive Titers Measles Date:_____ Mumps Date_____ Rubella Date_____	mo/day/yr #1_____

Chickenpox History
☐ Check the box if this person has a physician-certified reliable history of chickenpox.
Reliable history may be based on:
- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity (attach copy of lab report)

Chickenpox history is **not acceptable for nursing students*

Recommended Meningitis Vaccine: (date and type of vaccine) _____ ***or enclosed signed waiver***
(must be within 5 years)

Are there any abnormalities of the following:

1.	skin, blood	Y	N	6.	neurologic/seizures	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.	hernia (males only)	Y	N
					testes_____hernia_____tanner_____		

If "yes" to any of the above explain_____

Allergies _____

Recommendations for physical activity: ❑ Unlimited ❑ Limited

Is the student fit to participate in collegiate competition? ❑ Yes ❑ No

Define activities to be restricted, if applicable: _____

_____

Required for all participants on athletic teams:
Sickle Cell lab report (please attach)
Urinalysis_____HGB or HCT_____

Femoral pulse (indicate 1-4+) R_____L_____
Apical heart rate Lying_____
Sitting_____

Provider signature_____ Date of exam _____

Provider address _____ Telephone _____