



The Engle Center for Counseling & Health Services

HEALTH RECORD AND EXAMINATION

TO BE COMPLETED BY M.D., D.O., P.A., C.R.N.P.

TO BE COMPLETED BY PROVIDER (within 1 year prior to participation)

PLEASE LIST DRUG ALLERGIES

Name (Last, First, MI) _____

Age _____ Date of Birth _____ Sex _____ HT _____ WT _____

Standing BP _____ Sitting BP _____ Pulse _____

Glasses: YES NO Contact Lenses Yes No Eye Protection Yes No Vision R L Anisocoria R L

Check each item N (Normal) or A (Abnormal)

Table with columns: HEENT, Comments, Comments, Medications with or without a prescription. Rows include Fundoscopic Exam, Ears, Mouth, Throat, Cardiac, Abdomen, Genitalia, Hernia, Skin, MUSCULOSKELETAL, Neck, Thoracic/Lumbar, Shoulder, Elbow, Wrist/Hands.

* If answered Abnormal, must have documentation from specialist.

Special Dietary/Nutrition Needs

Please identify any food allergy or intolerance:

___ Citrus; ___ Corn; ___ Egg; ___ Fish; ___ Milk/Dairy; ___ Peanut; ___ Shellfish; ___ Soy; ___ Strawberry; ___ Tree Nut; ___ Wheat; ___ Other _____

If you have checked yes to any of these, briefly describe your reaction to the food: _____

Please list medical treatment in case of accidental exposure: _____

Please provide medical documentation for food allergy diagnosis, and/or list health care provider who is providing treatment for this condition: _____

Please list any other nutrition related conditions that would indicate a special diet: _____



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Name _____ D.O.B _____

Please have your provider attach a copy of your immunizations. Following is a list of Immunizations that are needed:

Required:

- Hepatitis B
MMR - 2 doses after 12 months of age
Meningitis - or a signed waiver
Polio - Childhood Series
TB Test within one year - if TB test is positive you need to send a copy of the x-ray report.
Tetanus or TDap - within 10 years

Recommended but Not Required. Note: Some of the following may be required if you plan to travel out of the country.

- Gardasil
Hepatitis A
Polio - booster after 18 years of age
Varicella

I have reviewed the medical history and herewith certify that the above student has been evaluated in the following areas as indicated below to be physically fit to participate in collegiate, club sport, and recreational sport activities.

Table with 4 columns: Medical History, Y/N, Cleared for, Not Cleared for. Rows include Medical Exam, Musculoskeletal, Collegiate Sports, Contact Sports, and Noncontact Sports.

Due to (if not cleared) _____

Modifications or exceptions: _____

How long have you been patient's physician? _____ Date of Exam _____

Signature of Provider: _____ Print Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Please Mail Health Form to:
Messiah College
Box 3028
Grantham, PA 17027
Phone (717) 691-6035 Fax (717) 796-5372