The Engle Center for Counseling & Health Services

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

within **6 months prior to sports participation** and/or
1 year prior to entrance into Messiah College

Name (Last, First, MI)_________________________________ **Age**_____ **D.O.B**___________ **Gender** ___________

Height _________________________ **Weight**________________________ **BMI** _____________________

Medication Allergies:____

Reaction: ____

Blood Pressure __________________________________ **Pulse** ____________________________

Provider: attach a complete copy of student immunizations.
The following is a list of immunizations that are REQUIRED:

Absolutely Required:

MMR – 2 doses after 12 months of age
Tdap (Td is NOT accepted) – within 10 years
Meningitis - (2 meningococcal vaccines (MCV4 or MPSV4) lifetime OR 1 vaccine is acceptable if given in the last 5 years)
Varicella-2 doses at least 4 weeks apart
Negative TB Screening Form (online) or skin test within one year – If TB test is positive you need to send a copy of the x-ray report or labwork
Athletes only: Sickle Cell Trait Status Verification

****FAILURE TO PROVIDE US WITH PROOF OF THESE REQUIRED IMMUNIZATIONS WILL RESULT IN AN INABILITY TO REGISTER FOR CLASSES**

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 reaction to the food:_____________________________

Please describe the patient's food restrictions or requirements, including the level of avoidance needed for each food or ingredient: ____

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:

____

☐ Check box if you are willing to have your **special dietary needs** shared with Dining Services

List any current health problems:

____

____

Name (Last, First, MI)____ **DOB**___________________

List current medications, including dosages and instructions:

____

____

Check each item N (Normal) or A (Abnormal)						
HEENT		**Comments**			**Comments**	Medications with or without prescriptions
Fundoscopic			Dental			
Ears			Nodes			
Mouth			Lungs			
Throat			Thyroid			
Cardiac *						
Abdomen			Neuro *			
Genitalia			Depression/Anxiety			
Hernia			Other Psychological Disorders			
Skin						
MUSCULOSKELETAL						
Neck			Hip			
Thoracic/Lumbar			Quad/Hamstring			
Shoulder			Knee			
Elbow			Ankle/Feet			
Wrist/Hands			Gait			

*** If answered *Abnormal*, must have documentation from specialist**

I certify that I have reviewed this patient's medical history and that he/she has had a complete physical exam and has been found to be emotionally and physically fit to attend college, live on campus (if applicable) and participate in all activities, including possible collegiate sport activities.

Cleared for ALL activities including Collegiate Sports □ **Not cleared** □

If not cleared, please specify activities patient cannot participate in, reason and qualifications to allow full clearance:

____

____

Any concerns regarding emotional or physical fitness for on campus living:

____

Date of Exam: ______________

Signature of Provider: __________________________ **Print Provider Name:** ______________________

Address:

____

____

Phone number: ______________________________ **Fax Number:** ___________________________

Once completed, form must be UPLOADED to Patient Portal

The Engle Center for Health Services
1 College Avenue, Suite 3028, Mechanicsburg, PA 17055
Phone (717)691-6035
Website: http://www.messiah.edu/info/20894/engle_center

Patient Portal: https://messiah.studenthealthportal.com/