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 5 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.

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:

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________
List current medications, including dosages and instructions:

___________________________________________________________________________________________________
___________________________________________________________________________________________________

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<td>Wrist/Hands</td>
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* 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/