MESSIAH UNIVERSITY

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 University

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

Height _____ **Weight** _____ **BMI**_____ **Blood Pressure** _____ **Pulse** _____

Current medications, include dosage & instructions _____

_____

Medication Allergies (Reaction):_____

Provider: Attach a complete copy of Immunization Records. **FAILURE TO PROVIDE US WITH PROOF OF THESE REQUIRED IMMUNIZATIONS WILL RESULT IN AN INABILITY TO REGISTER FOR CLASSES

Absolutely Required:

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

Name of Required Vaccine	**MMR** (2 doses after age of 12 months)	**Tdap** Within 5 years (Td is NOT accepted)	**Meningitis** (2 meningococcal vaccines (ACYW) lifetime **OR** 1 is acceptable if given in the last 5 years)	**Varicella** (2 doses at least 4 weeks apart) OR **Varicella Titer**
Date of Dose 1				
Date of Dose 2 (If required)		✕		

Are all of the above immunizations complete? Yes ☐ No ☐ If "No" date of planned vaccination _____

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**

Name (Last, First, MI)_____

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: _____

_____

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, Physical form and Immunization Record 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/