MESSIAH UNIVERSITY

School of Graduate & Professional Studies
One University Ave.
Mechanicsburg PA 17055

## Graduate Student Physical Examination Form

Last Name: First Name: Date of Birth: Gender: M / F

Home Address: City: State: Zip:

Emergency Contact: Relationship: Phone Number:

**TO THE EXAMINER: Please perform a physical examination and comment on all positive answers. Healthcare provider must hold licensure as a physician, nurse practitioner, or physician assistant.**

Height: Weight: Blood Pressure:

*Are there abnormalities in the following areas?*

| *Body System* | *Yes* | *No* | *Comments:* |
|---|---|---|---|
| Skin | | | |
| Head, Ears, Nose or Throat | | | |
| Eyes | | | |
| Respiratory | | | |
| Cardiovascular | | | |
| Gastrointestinal | | | |
| Hernia | | | |
| Genitourinary | | | |
| Musculoskeletal | | | |
| Metabolic/Endocrine | | | |
| Neuropsychiatric | | | |

***Laboratory Tests and Immunizations*:**

Please complete ALL of the following and include the dates (or attach immunization record)

TB test: Type: Date: Result:

If positive TB test, date of chest x-ray (within past 12 months): Result (within past 12 months):

Isoniazid Prophylaxis RX? Yes / No Dates:

| *Immunizations* | *Date(s)* | | *Titer date and result* (cannot say "had disease") |
|---|---|---|---|
| Varicella | | | |
| Measles/Mumps/Rubella | | | |
| Tdap (within last 10 years AND age 10+) | | | |
| Hepatitis B | | | |

***Health Care Provider*:** Signing below indicates that you have found the named student to be in good physical and mental health, free from any health impairment which is of potential risk to patients, personnel, students, or faculty and which might interfere with the performance of his/her graduate student responsibilities, and able to participate fully in a clinical or field work experience.

Signature of Examiner Printed Name Credentials Date

Address Phone Number