PHYSICAL EXAMINATION

THIS FORM IS TO BE COMPLETED AND SIGNED BY A LICENSED HEALTH CARE PROVIDER.

The NCAA requires all ATHLETES to have a physical exam within 6 months of starting school.

Student's Name: ______________________________________ Date of Birth: _____/_____/_____
Month Day Year

Weight __________ Height __________ BP __________ Pulse __________ Glasses ❑ Contacts ❑ Hearing aid ❑

SYSTEM	NORMAL	ABNORMAL (PLEASE DESCRIBE)
Appearance		
Skin		
HEENT		
Mouth, Teeth, Gingiva		
Lungs/Chest		
Breasts		
Cardiovascular		
Gastrointestinal		
Abdomen (rectal if indicated)		
Hernia		
Genito-urinary		
Pelvic (if indicated)		
Lymphatic		
Musculoskeletal		
Neurological		
Endocrine		
Psychological		

Lab work recommended: Hgb/Hct ________ Cholesterol ________ LDL ________ HDL ________ Urine: Glucose ________ Protein ________ Blood ________

Sickle Cell Trait Status (**Required for ATHLETES**) ____________________________

CURRENT MAJOR and CHRONIC PROBLEMS

____

____

____

ACUTE or MINOR PROBLEMS

____

____

____

ALLERGIES: *(Medications, insect venom, foods, etc.)* ____

Type of Reaction ____ Does the student have an Epi-pen? ❑ yes ❑ no

CURRENT MEDICATIONS: ____

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL ACTIVITY, I.E. PHYS. ED., INTRAMURALS, SPORTS:

❑ Unlimited - cleared for full participation **OR** ❑ Limited - not cleared for full participation (specify limits) ____________________________

____

Do you have any dietary recommendations? ____

General appraisal of this student's health and emotional stability. ____

____

Do you have any recommendations regarding the care of this student?____

____

Do you know of any condition that will affect health or studies? ____

____

Licensed Medical Provider Verification (MD, DO, PA, NP) • REQUIRED

Provider's Printed Name____ Date of exam _______/_______/_________

Address (Including City and State) ____ Phone ______________________

Provider's Signature/Credentials ____ FAX __________________________

IMMUNIZATION RECORD

DOCUMENTATION OF IMMUNIZATIONS IS TO BE COMPLETED AND SIGNED BY A LICENSED HEALTH CARE PROVIDER.

Print Last Name: ______________________ Print First Name:______________________ Date of Birth: _____/_____/_____
Month Day Year

REQUIRED IMMUNIZATIONS

The Commonwealth of Massachusetts and ENC require all students (residential and commuter) to be immunized against certain communicable diseases. All dates must include month, day and year. To comply, have this form completed and signed by your healthcare provider unless there is a copy of an immunization record. Once completed by the provider, the student must submit all documents to ENC Health Services as soon as possible and no later than July 31 (Fall enrollment) and November 30 (Spring enrollment). **If providing serologic proof of immunity, you must include laboratory test results when submitting this form.**

REQUIRED VACCINES	DATES GIVEN	MA STATE REQUIREMENTS
MMR (Measles, Mumps, Rubella) Series of 2 immunizatoins OR Laboratory evidence of immunity is acceptable in lieu of immunization	MMR: #1 _____/_____/_____ #2 _____/_____/_____ OR **Measles** ❑ Immune – Titer Value ______________ Date ___/____/____ **Mumps** ❑ Immune – Titer Value ______________ Date ___/____/____ **Rubella** ❑ Immune – Titer Value ______________ Date ___/____/____	Dose #1 must be given on or after the 1st birthday Dose #2 must be given ≥ 28 days after the first dose OR laboratory evidence of immunity is acceptable
Tdap (Tetanus-Diphtheria-Pertussis)	Tdap Vaccine Date _____/_____/_____ *If ≥ 10 years ago, you must also provide date of current Td or Tdap _____/_____/_____	Tdap must be given on or after age 7. *NOTE: If Tdap was given ≥10 years ago, you must also provide a current Td or Tdap vaccine.
Hepatitis B Series of 3 immunizations OR 2 immunizations of Heplisav-B* OR Laboratory evidence for immunity is acceptable in lieu of immunization	**Vaccine name** ________________________ #1 _____/_____/_____ #2 _____/_____/_____ #3 _____/_____/_____ OR ❑ Immune – Titer Value ________ Titer Date _____/_____/_____	Dose #1: May be given at any age. Dose #2: at least 4 weeks (28 days) after dose #1. Dose #3: given at least 8 weeks (56 days) between #2 and #3. There must be at least 16 weeks (112 days) between #1 and #3. *NOTE: 2 doses of Heplisav-B must be given on or after 18 years of age and at least 4 weeks apart OR proof of serolgic immmunity is acceptable*.
Varicella – Chickenpox Series of 2 immunizations OR Laboratory evidence for immunity is acceptable in lieu of immunization OR Reliable history of Chickenpox	#1 _____/_____/_____ #2 _____/_____/_____ OR ❑ Immune – Titer Value _________ Titer Date ___/____/____ OR ❑ Reliable history of Chickenpox Disease*	Dose #1must be given on or after 1st. birthday. Dose #2 must be given at least 28 days after dose #1 OR Proof of serologic immunity is acceptable*. *NOTE: A reliable history of chickenpox disease MUST BE SIGNED below by an MD, PA, or NP.
Meningococcal Quadrivalent Required for students 21 years of age or younger; vaccine must be given on or after 16th birthday	MenACWY Vaccine Date _____/_____/_____ Check which vaccine was administered: ❑ Menactra ❑ Menveo ❑ Other __________________ OR ❑ Signed Waiver Form*	Meningococcal Information and Waiver Form *Please sign after reading the MDHP Meningococcal Information form.
STRONGLY RECOMMENDED / ADDITIONAL IMMUNIZATIONS AND STANDARD DOSING		
COVID-19 Date of most recent dose	Date _____/_____/_____	Accepted Vaccines: Pfizer-BioNTech; Moderna; WHO EUL Vaccine
Influenza Date of most recent dose	Date _____/_____/_____	The CDC recommends that everyone 6 months and older in the United States should get a flu vaccine every season with rare exceptions.
Meningococcal Group B MenB-4C (Bexsero)	#1 _____/_____/_____ #2 _____/_____/_____	2 doses - Second dose at least 1 month after the first dose
Meningococcal Group B MenB-FHbp (Trumenba)	#1 _____/_____/_____ #2 _____/_____/_____ #3 _____/_____/_____	2 or 3 doses - For those not at risk, 2 doses, second dose 6 months after the first dose. Those at increased risk 3 doses. Second dose 1-2 months after first dose. Third dose 6 months after the first
HPV (Human Papillomavirus)	#1 _____/_____/_____ #2 _____/_____/_____ #3 _____/_____/_____	3 doses over 6 months. Reommended for everyone through age 26

Licensed Medical Provider Verification (MD, DO, PA, NP, RN) • REQUIRED

Provider's Printed Name______________________________________ Date ______/______/________

Address (Including City and State) ______________________________ Phone ________________

Provider's Signature/Credentials ________________________________ FAX ________________

MEDICAL EVALUATION FOR LATENT TUBERCULOSIS INFECTION

THIS FORM IS TO BE COMPLETED AND SIGNED BY A LICENSED HEALTH CARE PROVIDER.

Student's Name: ________________________________ **Date of Birth:** _____/_____/_____

PLEASE NOTE: If the answer to all questions on Med+Proctor's TB Questionnaire is "NO," then a TB Test is NOT NEEDED.

A. TB Test – ONLY REQUIRED if the student answered YES to any question on Med+Proctor's TB Questionnaire.
If needed, a TB test must be completed within 6 months prior to entrance into ENC. However, if the student has had a positive IGRA (TB blood test) in the past, then follow additional requirements in section B below.

OPTION 1 (Preferred): IGRA – INTERFERON GAMMA RELEASE ASSAY

Date obtained ____/____/____ (specify method) ❑ QFT-GIT ❑ T-Spot ❑ Other________________

Result ___________________________________

OPTION 2: TUBERCULIN SKIN TEST

Date test administered: ____/____/____ Date test read: ____/____/____ Result _____mm of induration

INTERPRETATION OF TUBERCULIN SKIN TEST: *(Please use table below)* ❑ Negative ❑ Positive

If TB skin test is POSITIVE, then an IGRA test is required.

INTERPRETATION GUIDELINES	
> 5 mm is positive:	• Recent close contacts of an individual with infectious TB • Persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease • Organ transplant recipients and other immunosuppressed persons (including receiving equivalent of > 15 mg/d of prednisone for > 1 month.) • HIV-infected persons
> 10 mm is positive:	• Foreign born or travelers to the U.S. from high prevalence areas or who resided in one for a significant* amount of time • Residents, employees, or volunteers in high-risk congregate settings • Persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight ** The significance of the travel exposure should be discussed with a health care provider and evaluated.*
> 15 mm is positive:	• Persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

B. If IGRA is POSITIVE, either now or by a previous history, then all of the following are required:

1. Date of positive IGRA
   Date: ____/____/____
2. Chest X-ray: Required (Attach report, NOT the X-ray)
   Date: ____/____/____
   ❑ Normal ❑ Abnormal ____
   Describe
3. Clinical Evaluation:
   ❑ Normal ❑ Abnormal ____
   Describe
4. Treatment
   ❑ Yes ____
   Drug, dose, frequency and dates
   ❑ No (Explain) ____

Licensed Medical Provider Verification (MD, DO, PA, NP) • REQUIRED

Provider's Printed Name________________________________ Date _________ / ________ / ___________

Address (Including City and State) ________________________________ Phone ______________________

Provider's Signature/Credentials ________________________________ FAX________________________