Physical Exam

GRINNELL COLLEGE

PHYSICIAN'S REPORT OF HEALTH EVALUATION – Date of Physical Exam must be between 08-26-2020 to 08-26-2021

To the Examining Physician: Please review the student's report and complete this physician's form. No other form will be accepted. **We ask that you complete the immunization section and provide a copy of the student's immunization record for verification. This form must be signed and dated to be accepted.** Since this student has already been accepted for admission, the information supplied will not affect their status and will be used only as background for providing any needed care by Student Health and Wellness and/or Athletics. This information will not be released to any requesting party without the student's written consent. **This form, along with a copy of the student's immunization record, and TB Form if applicable, should be given to the student who will return it to the College.**

Legal Name: _____
Last First Middle

Name-In-Use: _____
Last First Middle

Date of Birth: _____ (month/day/year)

Sex assigned at birth: ☐Female ☐Male Legal Sex: ☐Female ☐Male

Gender Identity: ☐Female ☐Male ☐Genderqueer ☐MtF Female ☐FtM Male ☐Non-binary

Pronouns-In-Use: ☐ she/her/hers ☐ he/him/his ☐ they/them/theirs ☐ other _____

Blood Pressure: _____ Weight: _____ Height: _____

Are there any abnormalities of the following systems?

	No	Yes	Describe fully
Head, Ears, Nose, or Throat			
Respiratory			
Cardiovascular			
Hernia			
Eyes			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			

Is the patient under the care of a medical specialist for any medical condition? ☐Yes ☐No

If yes, please explain: _____

_____

Is the patient under treatment for any psychological condition? ☐Yes ☐No

Diagnosis: _____

Do you have any recommendations regarding the care of this patient? ☐Yes ☐No

_____

_____

Recommendations for physical activity/athletics: ☐Unlimited ☐Limited

Explanation: _____

_____

Physician's Signature: _____

Practice Name: _____

Practice Address: _____

Practice Phone Number / Fax Number: _____ / _____

DATE OF EXAM: _____

DATE OF EXAM: _____

Medications: ***(please list below)*** ☐ **None**

_____

_____

Allergies: ***(please list below)*** ☐ **None Known**

_____

_____

REQUIRED Immunizations

COVID

☐ **Pfizer** ☐ **Moderna** ☐ **Johnson & Johnson / Janssen**

☐ **Other** ***(specify brand)*** _____

Dose #1 Date (month/day/year) _____

Dose #2 Date (month/day/year) _____

MEASLES/MUMPS/RUBELLA (MMR)

(Must have two MMR doses)

Dose #1 Date (month/day/year) _____

Dose #2 Date (month/day/year) _____

MENINGOCOCCAL QUADRIVALENT (A,C,W,Y)

☐ **Menactra** ☐ **Menveo** ☐ **MenACWY**

(Must be within 5 years)

Dose #1 Date (month/day/year) _____

Dose #2 Date (month/day/year) _____

SEROGROUP B MENINGOCOCCAL

☐ **Bexsero** ☐ **Trumenba**

(Must complete series)

Dose #1 Date (month/day/year) _____

Dose #2 Date (month/day/year) _____

TETANUS, DIPHTHERIA

☐ **Td** ☐ **Tdap** ***(Must be within 10 years)***

Primary series completed? ☐ Yes ☐ No

Booster Dose Date (month/day/year) _____

VARICELLA ***(Must have two varicella doses)***

Dose #1 Date (month/day/year) _____

Dose #2 Date (month/day/year) _____

If you had the chicken pox disease, physician to verify the date of disease (month/day/year) _____

NOTE: If titers are obtained the student is required to submit a copy of the laboratory results to Grinnell College.

INFLUENZA ***(2021-2022 Season)***

Dose #1 Date (month/day/year) _____

TUBERCULIN SKIN TEST

Complete the online Tuberculosis Risk Screening to determine if you will need a TB Skin Test. If the answer is yes, download the Clinical Tuberculosis Assessment by Health Care Provider form for your physician to complete.

RECOMMENDED Immunizations

HEPATITIS A VACCINE
HEPATITIS B VACCINE
HUMAN PAPILLOMAVIRUS (HPV) VACCINE
POLIO VACCINE