Grinnell College
Student Health and Wellness

Student Physical Exam

Date of Physical Exam must be within one year of arrival to Grinnell College (must be after August of previous year). **Athletes** must have a physical exam after April 1 of current year, according to NCAA requirements.

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 Initial

Name-In-Use: _____
Last First Middle Initial

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: ☐ she/her/hers ☐ he/him/his ☐ they/them/theirs ☐ other _____

To be completed by primary care provider.

To the Examining Physician: Please review the student's report and complete this physician's form. No other form will be accepted.

DATE OF EXAM: _____

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: _____

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

_____

_____

_____

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

_____

_____

_____

A complete immunization record must accompany this form. Please confirm that the student has received all required immunizations.

Physician's Signature: _____

Practice Name: _____

Practice Address: _____

Practice Phone Number / Fax Number: _____ / _____

REQUIRED Immunizations

Please attach documentation of the immunizations. Students will need to enter this data into the student health portal. Please note, if you require a second dose of any immunization, you will need to supply documentation of this dose to SHAW. If your doctor's office does not have this immunization, we suggest contacting your local Public Health Department or local pharmacy. International students whose countries do not provide certain immunizations will have an opportunity to schedule needed vaccines upon arrival. Requests for exemption can be sent to shaw@grinnell.edu.

Measles/Mumps/Rubella (MMR)

MMR is a 2-dose series. First dose must have been received **after** 12 months of age to qualify.
Titers can be obtained as proof of immunity. NOTE: Laboratory results of titers must accompany this form.

Meningococcal Quadrivalent (A, C, W, Y)

Must be received at or after age 16 or a booster is required.

- Menactra
- Menveo
- Men ACWY

Serogroup Meningococcal B

Must receive 2 doses of the same brand of vaccine. These brands are NOT interchangeable.

- Bexsero (2 dose series, 6 months between doses)
- Trumenba (2 dose series, 6 months between doses)

Tetanus, Diphtheria, Pertussis

Last dose must have been within 10 years.

- Td
- Tdap

Varicella

Varicella is a 2 dose series. First dose must have been **after** 12 months of age to qualify.
If you had the chicken pox disease, a physician **must** verify the date of disease (month/day/year) to eliminate the need for vaccination. ***Titers can be obtained as proof of immunity. NOTE: Laboratory results of titers must accompany this form.***

Tuberculosis Screening ***See next page for details***

*Screening lab tests are not covered by insurance. Students are responsible for the cost of testing.

RECOMMENDED Immunizations

- **Hepatitis A Vaccine**
- **Hepatitis B Vaccine**
- **Human Papillomavirus (HPV) Vaccine**
- **Polio Vaccine**
- **COVID-19**
  Grinnell College **strongly** encourages all students to be fully vaccinated (including a booster dose)

Tuberculosis Screening

Please complete the *online* Tuberculosis Screening from.

As some students may be going to a physician before they complete the form, the questions are provided here.

If you answer yes to any of the below questions, you will need the Clinical Assessment Form (*see next page*).

1. Have you ever had a positive Tuberculin skin test (PPD)?
2. Have you had close contact with someone who was diagnosed with Tuberculosis?
   Close contact is defined as having shared air space with an individual with Tuberculosis in an indoor setting for more than 15 hours per week.
3. Were you born in one of the countries listed below AND arrived in the U.S. within the past 5 years?
4. Have you traveled or lived for more than 1 month in one or more of the countries listed below? If yes, please check the country below.
5. Have you ever been vaccinated with BCG?
6. You have spent significant time (over 30 days??) in one of the below countries in the last 5 years.

World Health Organization (WHO): List of High-Risk Tuberculosis Exposure Countries

Angola
Bangladesh
Brazil
Central African Republic
China
Congo (Republic of the Congo)
Democratic People's Republic of Korea (North Korea)
Democratic Republic of the Congo
Ethiopia
Gabon
Guinea
Guinea-Bissau
Haiti
India
Indonesia
Kenya
Lesotho
Liberia
Mozambique
Myanmar
Namibia
Nigeria
Pakistan
Papua New Guinea
Philippines
Sierra Leone
South Africa
Tanzania (United Republic of)
Viet Nam
Zambia

Student Name: _____ Date of Birth: ____/____/___
Last First Middle M D Y

Clinical Tuberculosis Assessment by Health Care Provider

Persons answering YES to any of the questions on the Online Tuberculosis Screening Form are required to complete this form with their medical provider. Please write dates as Month, Day, Year.

1. Does the student have signs or symptoms of active pulmonary tuberculosis disease?

☐ Yes ☐ No **- If No, proceed to 2 or 3**

If yes, check below:

☐ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
☐ Coughing up blood (hemoptysis) ☐ Chest pain ☐ Loss of appetite
☐ Unexplained weight loss ☐ Night sweats ☐ Fever

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST) – Must be performed within six months of entrance to Grinnell College. TST result should be recorded as actual millimeters (mm) of induration (hard, dense, raised formation). If no induration, write "0". **A test ≥ 10 mm of induration is considered positive.**

Date Test Placed: ____/____/____ **Date Test Read**: ____/____/____ **Result**: _____ mm of induration

3. Interferon Gamma Release Assay (IGRA) – Only needed if positive TST results ≥ 10 mm of induration. Testing must be performed within six months of entrance to Grinnell College.
The Quantiferon Gold blood test may be obtained in Grinnell. This blood test is not covered by insurance.

Date Obtained: ___/____/____ (Month, Day, Year)

Specify method: ☐ QFT-G ☐ QFT-GIT ☐ T-Spot ☐ other_____

IGRA Result: (The actual lab report is required and written or translated into English)

☐ **Negative** ☐ **Positive – All positive IGRA results require a chest x-ray.**
Stand-alone chest x-ray will not satisfy TB requirement.

4. Chest x-ray: Only needed **if IGRA laboratory result is positive.**
Date of Chest x-ray: ____/____/____ (Month, Day, Year)
Result: ☐ **Normal** ☐ **Abnormal (seek immediate medical attention)**
All Chest X-Rays must be from the US and within the last 90 days.

5. Did the student receive treatment? ☐ Yes ☐ No

If yes, what medication regimen was prescribed?

_____

Date treatment started:
____/____/____

Date treatment completed:
____/____/___

Physician's Signature: _____

Practice Name: _____

Practice Address: _____

Practice Phone Number / Fax Number: _____ / _____

DATE OF EXAM:

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