University of New Hampshire

# Health Services Physical Exam Form

## STUDENT INFORMATION

Name: _____ Date: _____ Age: _____ Date of Birth: _____

Preferred Name: _____ Pronoun: _____

Address: _____ State: _____ ZIP: _____

Height: _____ Vision: R _____/_____ corrected □ / uncorrected □ Glasses? Yes □ No □
Weight: _____ L _____/_____ corrected □ / uncorrected □ Contacts? Yes □ No □

| | Normal | Abnormal | Comments |
|---|---|---|---|
| Eyes, Ears, Nose, Throat, Mouth & Teeth | | | |
| Neck, Thyroid | | | |
| Cardiovascular | | | |
| Chest & Lungs | | | |
| Abdomen | | | |
| Skin | | | |
| Genitalia-Hernia<br><br>Testicular Exam | | | |
| Musculoskeletal (ROM, strength, etc.) | | | |
| neck □ shoulders □ arms □ | | | |
| hands □ back □ hips □ | | | |
| knees □ feet □ legs □ | | | |
| Neurological | | | |
| Date of last gynecological exam<br><br>Pap smear date & result<br><br>Breast exam | | | |

THIS SECTION IS ONLY **MANDATORY FOR INTERCOLLEGIATE ATHLETES**

SICKLE CELL TRAIT: Positive _____ Negative _____ Unknown Status _____ (must be screened or sign waiver)

- Attach lab result of sickle cell trait screening (if available) or signed UNH Sickle Cell Waiver form
- The NCAA encourages ALL Intercollegiate athletes to be aware of their sickle cell trait status
- Waiver form available at: http://unhwildcats.com/Athletic_Training/Athletic_Training_home_page

Pulse: _____ Blood Pressure: _____/_____ Hearing: _____

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- Does the student use tobacco products (cigarettes, cigars, chew, snuff or electronic cigarettes)? Yes □ No □
  If yes, have you discussed the risk? Yes □ No □
- Has education about the use of alcohol, steroids, dietary supplements and other drugs, including misuse/abuse of prescription medication, been offered to this student? Yes □ No □
- Have you discussed safer sex issues with this student? Yes □ No □



The Health Services Physical Exam Form must be completed by a physician or a nurse practitioner/physician's assistant. The student should upload the completed form online at www.unh.edu/health-services/incoming-students.

University of New Hampshire

# Health Services Physical Exam Form

*Continued from front*

Please comment on whether further evaluation or care is needed: _____

_____

_____

_____

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

**Recommendations for Physical Activity**: Exercise programs & use of fitness equipment. Unlimited □ Limited □

**Intercollegiate & Recreational Sports:** Is this student capable of participating in a full program of college study, including participation in intercollegiate sports/intramural or club sports? Yes □ No □

□ Cleared after completing evaluation/rehabilitation for: _____

Recommendations:

_____

_____

_____

**PRACTIIONER INFORMATION**

Clinician's Signature: _____ Date:_____

Clinician's Name, Address & Telephone (please print):

_____

_____

_____

**SUBMITTING THIS FORM**

**All students:**

Upload the completed form online at www.unh.edu/health-services/incoming-students.
Contact Health Services at (603) 862-9355 with any questions.

**Students participating in Division I Intercollegiate Sports, please mail a copy of the physical exam form to:**

UNH Athletic Training
145 Main St., Field House
Durham, NH 03824

**STUDENT:** I give consent for this form to be copied and released to the Athletic Department upon request.
*(Please complete in case permission is needed at a later date.)*

Signature: _____ Date: _____



The Health Services Physical Exam Form must be completed by a physician or a nurse practitioner/physician's assistant. The student should upload the completed form online at www.unh.edu/health-services/incoming-students.

University of New Hampshire

# Health Services Immunization Record Form

The university requires verification of immunizations and/or serological test for Measles, Mumps, and Rubella (exact dates required). If documentation is not received by the deadline, an academic hold may be implemented. This form is to be completed by a health care clinician.

**Student Name:** _____ **Preferred Name:** _____ **Date of Birth:** _____

| Vaccines | Dates Given | NH Requirements & Recommendations |
|---|---|---|
| MMR | #1: ___/___/___ #2: ___/___/___ | 2 doses for MMR (Measles, Mumps, Rubella), with first dose given after 1st birthday; positive titers (include copy of lab work); or 2 doses Measles, 2 doses Mumps and 1 dose Rubella |
| | OR | |
| Measles | #1: ___/___/___ #2: ___/___/___ Titer: ___/___/___ | |
| Mumps | #1: ___/___/___ #2: ___/___/___ Titer: ___/___/___ | |
| Rubella | #1: ___/___/___ Titer: ___/___/___ | |
| Tdap/Td | Tdap: ___/___/___ Td: ___/___/___ | Tdap/Td booster within the last 10 years |
| Meningococcal ACWY | #1: ___/___/___ #2: ___/___/___ | Meningococcal ACWY is recommended for all 1st year students living in residence halls. Talk with your clinician about these vaccinations. |
| Meningococcal B | #1: ___/___/___ #2: ___/___/___ #3: ___/___/___ | |
| Varicella (chicken pox) | #1: ___/___/___ #2: ___/___/___<br>**OR** Illness: ___/___/___<br>**OR** Titer: ___/___/___ | History of illness, 2 doses of Varicella vaccine (minimum of 4 weeks between doses), or positive titer |
| Hepatitis B | #1: ___/___/___ #2: ___/___/___ #3: ___/___/___<br>**OR** Titer: ___/___/___ | 3 doses OR positive surface antibody titer |
| DTP/DTaP Series | Series completion: ___/___/___ | |
| Polio Series (OPV/IPV) | Series completion: ___/___/___ | |
| HPV Series | #1: ___/___/___ #2: ___/___/___ #3: ___/___/___ | |
| TST (Tuberculin Skin Test) Mantoux Method | Date administered: ___/___/___ Results: ___ mm<br>Date read: ___/___/___<br>Chest x-ray date: ___/___/___ Include a copy of the chest x-ray. | **Required only if at high risk.** Students must complete the Tuberculosis Screening at unh.edu/health-services/incoming-students to determine risk. |
| History of BCG | Date: ___/___/___ | |
| Other Vaccines | Date: ___/___/___<br>Date: ___/___/___<br>Date: ___/___/___ | |

The above-named patient is requesting exemption from the immunizations requirements/recommendations. Please provide proper documentation supporting the exemption(s). [ ] Health [ ] Religious [ ] Other

**Health care clinician** _____ _____ _____
**(Signature)** **(Print name)** **(Date)**

**Address:** _____ **Telephone:** (_____)_____

The Health Services Immunization Record Form must be completed by a physician or a nurse practitioner/physician's assistant. The student should upload the completed form online at www.unh.edu/health-services/incoming-students.

**University of New Hampshire Health & Wellness**

Form #051.3

## Tuberculosis Testing and Treatment

**To be completed by Health Care Provider if ANY of the TB Screening Questionnaire questions are positive.**

1. Does this student have signs or symptoms of active tuberculosis disease? ___YES ___NO
   (If the answer is YES, please proceed with additional evaluation to exclude active TB disease and provide UNH Health Services with further detailed information documenting absence of disease or adequate treatment.)

2. Interferon Gamma Release Assay (IGRA) (preferred alternative to TST testing, esp. in international students)
   Date Obtained: _____/_____/_____ Specify method: ___QFT-G ___QFT-GIT ___Other
   M D Y M D Y
   Result: ___Negative ___Positive ___Intermediate

   Date Obtained: _____/_____/_____ Specify method: ___QFT-G ___QFT-GIT ___Other
   M D Y M D Y
   Result: ___Negative ___Positive ___Intermediate

3. Tuberculin Skin Test: *Must do if student has never had a positive test in the past.
   (TST result should be recorded as actual millimeters of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors. **)
   Date Given: _____/_____/_____ Date Read: _____/_____/_____
   M D Y M D Y
   Result: _____mm of induration **Interpretation: ___Positive ___Negative

   Date Given: _____/_____/_____ Date Read: _____/_____/_____
   M D Y M D Y
   Result: _____mm of induration **Interpretation: ___Positive ___Negative

4. Chest X-Ray (Required if TST or IGRA is or has ever been positive or if any signs or symptoms of active disease. Your health care provider can decide if a previous chest x-ray result is adequate or if a new one is needed.)
   Date of chest x-ray _____ Result: ___Normal ___Abnormal
   If abnormal, provide details_____

5. Treatment Information:
   a)Treated for latent TB infection (LTBI): Dates:_____ with _____
   (Medication and dose)
   b)Treated for active TB infection: Dates:_____
   Proof of cure_____

Clinician Signature: _____ Date: _____

**Interpretation Guidelines are listed on the reverse side of this page.

****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
- Immunosuppressed persons: taking >15 mg/d of prednisone for >1 month; taking a TNF –α antagonist
- Persons with HIV/AIDS

>10 mm is positive:

- Persons born in a high prevalence country or who resided in one for a significant amount of time
- History of illicit drug use
- Mycobacteriology laboratory personnel
- History of resident, worker or volunteer in high-risk congregate settings
- Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes

15mm is positive: Persons with no known risk factors for TB disease