Pre-Matriculation Physical Evaluation Form for Category B

January 1, 2017

Dear Doctor:

Please complete the attached pre-matriculation physical evaluation and perform a physical examination for our incoming student. The following is a list of **REQUIREMENTS** that must accompany this form. ***A copy of the results for all titers must accompany the form.*** Please contact our office at 215-955-6835 if you have questions. Some frequently asked questions are addressed on University Health Services' website: http://hospitals.jefferson.edu/departments-and-services/university-health-services/frequently-asked-questions/

Requirements:

1. Measles Immunity as documented by a positive IgG antibody titer **(copy must be attached).**
   a. If negative titer result for Measles, documentation of two MMR vaccines is needed (initial MMR series acceptable).

2. Mumps Immunity as documented by a positive IgG antibody titer **(copy must be attached).**
   a. If negative titer result for Mumps, documentation of two MMR vaccines is needed (initial MMR series acceptable).

3. Rubella Immunity as documented by a positive IgG antibody titer **(copy must be attached).**
   a. If negative titer result for Rubella, documentation of one MMR vaccine is needed (initial MMR series acceptable).

4. Varicella Immunity as documented by **2** Varicella vaccines **OR** positive IgG antibody titer **(copy must be attached)**.

5. Tetanus/Diphtheria/Pertussis Immunity as documented by:
   a. A recent dose of the Tdap (tetanus/diphtheria/acellular pertussis) booster, recommended within 5 years of your start date. Common brand names are Adacel and Boostrix. Tetanus/Td will **NOT** be accepted.

6. Hepatitis B Immunity as documented by:
   a. 3 doses of the vaccine **and** a positive Hepatitis B Surface Antibody
   b. If negative, receive 4th dose of the Hep B vaccine, repeat titer four weeks from the 4th dose.
   c. If repeat titer is positive, no further testing is needed.
   d. If repeat titer is negative, continue with doses 5 & 6 as scheduled.
   e. If Hep B Surface Antibody is negative after a secondary series (total of 6 doses), additional testing including Hep B Surface Antigen & Hep B Core Antibody should be performed.

7. Tuberculosis Screening
   a. IGRA Blood Test (Interferon Gamma Release Assay) is the required test, regardless of prior BCG status. To be performed within 3 months prior to the start of your first semester. Common brand names are Quantiferon-TB Gold and T-SPOT **(copy of lab report must be attached)**. PPD will **NOT** be accepted
   b. If positive history along with INH treatment, a copy of a chest x-ray report done within the past 6 months is required.

8. Meningitis Vaccination
   a. Only students **planning to reside in Jefferson housing** must consider this vaccine. These students must provide the date of vaccination or provide the signed waiver form available on our website.

9. Seasonal influenza vaccine is mandatory during Flu season (Aug - April)
   a. Free flu vaccine will be provided by University Health Services during the Fall semester
   b. If received outside of UHS, documentation is required. Include the following: date of vaccination, manufacturer, lot number, expiration date, signature of administrator.

Sincerely,

Ellen M. O'Connor, MD, FACP
Clinical Assistant Professor of Medicine
Medical Director, University Health Services

Last Name:		First Name:	
Date of Birth: / /	Sex: ☐ M ☐ F ☐ FtM ☐ MtF	SS#:	Campus Key:
Current Address:			
City:		State:	Zip:
Local Address:			
City:		State:	Zip:
Home Telephone: ( )		Cell Phone Number: ( )	
Jefferson E-mail Address:		@jefferson.edu	
In case of an emergency contact - Name		Emergency Contact - Phone ( )	
Previous Jefferson Student? (If yes, give program and year of graduation) ☐ No ☐ Yes		Current Jefferson Employee? ☐ No ☐ Yes	
Previous Jefferson Employee? ☐ No ☐ Yes		Employment Termination Date:	
Previous visiting student or volunteer? ☐ No ☐ Yes		If yes, date of visit or assignment:	

IF YOU DO NOT SEE YOUR PROGRAM LISTED, YOU HAVE THE WRONG FORM.

Program you are entering (please include Program on all correspondence)

COLLEGES/PROGRAMS/DEGREES	**Start Date**	**Expected Graduation Date**
Institute of Emerging Health Professions		
• Community Health Worker Certificate		
• Perfusion & Extracorporeal Technology		
College of Health Professions		
• Couple and Family		
• Medical Laboratory Sciences & Biotechnology: ☐ Bachelor ☐ Masters		
• Occupational Therapy: ☐ BSMS ☐ EMOT ☐ OTD		
• Physical Therapy: ☐ DPT		
• Physician Assistant Studies		
• Radiologic Sciences ☐ Bachelor ☐ RIMS (PET/CT, ICVT & CT) ☐ MPMS ☐ PET/CT Certificate		
College of Nursing		
☐ FACT-1 ☐ FACT-2 ☐ Prelicensure - Traditional Track ☐ MSN ☐ Post-Master's Certificate ☐ Post-Master's Certificate ☐ DNP ☐ Nurse Anesthesia (DNP)		
College of Pharmacy		

VERIFICATION OF INFORMATION

The following statements are true to the best of my knowledge. I understand that any false statement made purposely may be grounds for dismissal from the program.

STATEMENT OF CONFIDENTIALITY

All medical records within University Health Services are confidential and will not be released without written authorization from the student. For infection control purposes, I give my permission to have ONLY my immunization and/or tuberculosis screening information forwarded for future participation in affiliate programs. This permission is in effect until I graduate from Jefferson or leave my program. I am aware that I may revoke this permission at any time.

Signature _____ Date _____

Name (Print)	Date of Birth / /
Program	Graduation Year

Medical History: Do you have, or have you ever had any of the problems listed below? *(please check)*

☐ Asthma	☐ Chest pain	☐ Syphilis	☐ Jaundice	☐ Arthritis
☐ Wheezing	☐ Angina	☐ Stroke	☐ Gall bladder disease	☐ Gout
☐ Chronic Cough	☐ Night Sweats	☐ Persistent dizziness	☐ Ulcer disease	☐ Thyroid disease
☐ Coughing of blood	☐ Palpitations	☐ Persistent headache	☐ Blood in stool	☐ Diabetes
☐ Shortness of breath	☐ Leg swelling	☐ Seizure disorder	☐ Vomiting blood	☐ Undue fatigue
☐ Pneumonia	☐ Phlebitis	☐ Loss of consciousness	☐ Persistent diarrhea	☐ Excessive weight gain
☐ Emphysema	☐ Kidney stones	☐ Paralysis	☐ Anemia	☐ Excessive weight loss
☐ Tuberculosis	☐ Blood in urine	☐ Back trouble	☐ Bleeding	☐ Depression
☐ High Blood pressure	☐ Urinary tract infection	☐ Pain down leg	☐ Cancer	☐ Anxiety
☐ Rheumatic fever	☐ Difficulty with urination	☐ Numbness down leg	☐ Visual difficulty	☐ Eating Disorder
☐ Heart murmur	☐ Sexually transmitted disease	☐ Abdominal pain	☐ Hearing difficulty	☐ ADHD
☐ Heart attack		☐ Hepatitis	☐ Skin rash	☐ Bipolar Disorder

Do you have any medical problems not listed above? ☐ Y ☐ N

Please list specific problems:

Please list all surgical procedures:

Date	Procedure

Do you have allergies to medicine? ☐ Y ☐ N

If yes, please list (include penicillin, sulfa drugs, tetracycline, etc.) and include reaction:

Do you have a sensitivity to latex? ☐ Y ☐ N

If yes, please explain workup:

Do you have any physical, medical, or emotional problems that you think may warrant special arrangements at school?
☐ Y ☐ N

Comments:

Have you ever been hospitalized for any medical condition?
☐ Y ☐ N

If yes: Month(s)/Year(s) Reasons

Do you take medications regularly? ☐ Y ☐ N

If yes, please list (include vitamins, herbal supplements, birth control pills, etc.)

Do you smoke? ☐ Y ☐ N

If yes, how many cigarettes per day? / day

If no, have you ever smoked?

Do you drink alcohol? ☐ Y ☐ N

If yes, amount:

Do you have a history of alcohol or substance abuse? ☐ Y ☐ N

If yes, explain:

Do you have any medical complaints now? ☐ Y ☐ N

Comments:

Name (Print)	Date of Birth / /
Program	Graduation Year

Student Immunization Documentation

The following information is required prior to starting at Thomas Jefferson University.
To be filled out by Physician, Nurse Practitioner or Physician Assistant

MMR (Measles, Mumps, Rubella)		
Measles (Rubeola)	Measles/Rubeola (IgG), antibodies, titer Date: / /	Results: ☐ POS ☐ NEG ☐ EQUIV ☐ **Lab Report Attached**
Mumps	Mumps (IgG), antibodies, titer Date: / /	Results: ☐ POS ☐ NEG ☐ EQUIV ☐ **Lab Report Attached**
Rubella	Rubella (IgG), antibodies, titer Date: / /	Results: ☐ POS ☐ NEG ☐ EQUIV ☐ **Lab Report Attached**

Varicella (Chicken Pox)			
	Dose #1 Date: / / Dose #2 Date: / /	**OR**	Varicella (IgG), antibodies, titer Date: / / Results: ☐ POS ☐ NEG ☐ EQUIV ☐ **Lab Report Attached**

Tetanus/Diphtheria/Pertussis (TDAP) - Recommended within 5 years of your start date.
Vaccine Date: / / man/lot/exp:

Hepatitis B Immunity - LAB REPORT MUST BE ATTACHED			
Primary Hepatitis B Series	Dose #1 Date: / / Dose #2 Date: / / Dose #3 Date: / /	**Secondary Hepatitis B Series** (If no response to primary series)	Dose #4 Date: / / Dose #5 Date: / / Dose #6 Date: / /
Hep B Surface Antibody Date: / / Results: mIU/ml ☐ **Lab Report Attached**		**Hep B Surface Antibody** Date: / / Results: mIU/ml ☐ **Lab Report Attached**	
Hepatitis B Vaccine Non-responder (If Negative Hep B surface Antibody after Primary & Secondary Series	Hepatitis B Surface Antigen **(If negative 2nd titer)** Date: / / Results: ☐ **Lab Report Attached**		
	Hepatitis B Core Antibody **(If negative 2nd titer)** Date: / / Results: ☐ **Lab Report Attached**		
Chronic Active Hepatitis B	Hepatitis B Surface Antigen Date: / / Results: ☐ **Lab Report Attached**		
	Hepatitis B Viral Load Date: / / Results: ☐ **Lab Report Attached**		

Tuberculosis Screening - IGRA Blood Test (Interferon Gamma Release Assay) - LAB REPORT MUST BE ATTACHED			
To be performed within 3 months prior to the start of your first semester			
IGRA Blood Test (Interferon Gamma Release Assay	Date: / /	Results: _____	☐ **Lab Report Attached**
Positive History Only: Chest x-ray within 6 months required for all positive results			
Chest X-ray	Date: / /	Results: _____	☐ **Chest X-ray Report Attached**

Meningitis Vaccination - Only students planning to reside in Jefferson housing must consider this vaccine.	
Living in Jefferson Housing ☐ Yes ☐ No	Date of vaccine (If answered yes) _____ OR Date of declination _____

Influenza - Vaccination is required for students during Flu season (Aug - April). Fall incoming students will receive in September.	
Vaccine Date: / /	man/lot/exp:

MD/CRNP/PA-C Signature	Date
Printed Name	Phone # ( )
Address	

Name (Print)	Date of Birth / /
Program	Graduation Year

Physical Examination

BP /	**Pulse**	**Ht** ft. in.	**Wt** lb

	Normal	**Abnormal**	**Not Examined**	Remarks
General Health				
Skin				
Ears				
EOMS				
Pupils				
Fundi				
Nose/Mouth				
Carotids				
Thyroid				
Lymph Nodes				
Lungs				
Heart				
Abdomen				
Extremities				
Cranial Nerves				
Motor				
Sensory				
Reflexes				
Nursing / OT / PT Students ONLY (Back Exam)				
Back Exam				
Range of Motion				
Flexibility				

Visual Acuity (Snellen)		**Ishihara**
Vision: OD	OS	**Color Blindness Screen:** ☐ Normal ☐ Abnormal _____ # plates of _____
Corrected: OD	OS	**Date of Last Eye Exam:**

To the best of my knowledge, based on my exam today, I believe this patient is:

☐ fit to be a student ☐ fit to be a student with the following restriction:_____

☐ not cleared

MD/CRNP/PA-C Signature	Date:
Printed Name:	Phone #: ( )
Address:	