PHYSICAL AND IMMUNIZATION FORM FOR UNDERGRADUATES

FLORIDA MEMORIAL UNIVERSITY
A PROMISE. A FUTURE.

Office of Health Education
15800 NW 42nd Ave.
Miami Gardens Fl. 33054
P: 305-626-3120

All students must complete this form and submit it to the Office of Health Education.
NO OTHER FORM WILL BE ACCEPTED.
or guardian.

If attending in fall form is due July 31
If attending in spring form is due January 1

Incomplete or overdue forms will delay or stop registration

*Please note, all dates as month/day/year (MM/DD/YY).

LAST NAME | FIRST NAME | MIDDLE INITIAL | COLLEGE ID

☐ MALE ☐ FEMALE

DATE OF BIRTH (MM/DD/YYYY) | GENDER | EMAIL ADDRESS

PERMANENT ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE | CELL PHONE | CITIZENSHIP

EMERGENCY CONTACT - This is the person we will contact in the event you have a medical emergency at school.

EMERGENCY CONTACT - NAME/RELATIONSHIP | HOME PHONE | CELL PHONE | WORK PHONE

EMERGENCY CONTACT - ADDRESS | CITY | COUNTRY | POSTAL CODE | EMAIL ADDRESS

PERSONAL PHYSICIAN

PERSONAL PRIMARY PHYSICIAN | ADDRESS | PHONE | FAX

DO YOU HAVE HEALTH INSURANCE? ☐ **YES - Upload a Copy of the front and back of the Insurance Card for cerification** ☐ **NO**

Consent to Treat Authorization for Florida Memorial Univeristy. Without signature the FMU Student Health Center can not treat this student. Parent or Guardian must sign for student under 18 years of age. I authorize **FMU Student Health Center** to provide care and treatment to me (my child/legal ward) as deemed appropriate. This includes but is not limited to routine, urgent, emergency care, medication, immunization, diagnostic studies and referrals to hospitals, clinics and/or medical specialists deemed necessary by the college's medical and/or nursing staff. In the event of a life threatening emergency or serious illness/injury of which the Student Health Center is aware, I authorize the Student Health Center or college designee to notify my emergency contact. I verify that all medical and psychological information I have provided is complete and accurate. I will notify the Student Health Center hereafter of any changes in my health that occur while a student.

SIGNATURE OF STUDENT (REQUIRED) **DATE (MM/DD/YY)**

SIGNATURE OF PARENT/GUARDIAN FOR MINOR (REQUIRED) **DATE (MM/DD/YY)**

DO NOT WRITE BELOW THIS LINE

REVIEWED BY: Initials_____ Date _____

☐ Incomplete for:
- ☐ IMMUNIZATIONS
  - ☐ Measles ☐ Rubella ☐ Mumps ☐ Meningitis
- ☐ PE
  - ☐ Medical History ☐ TB Screen/TSpot ☐ Date of PE
  - ☐ Consent ☐ MD Signature ☐ Activity

Notified by: ☐ Letter ☐ Email ☐ Phone ☐ In-Person Initials _____ Date _____

☐ **PE and Immunization Complete:**
Initials _____ Date _____

☐ **Scanned:** Date _____

IMMUNIZATIONS

HEALTHCARE PROVIDER must complete and sign or stamp this page.
Immunization records attached to this form must be signed by an MD, DO, PA or NP.

NAME OF STUDENT | DATE OF BIRTH (MM/DD/YYYY)

MMR (Measles, Mumps, Rubella)	If born on or after 1/1/57, two doses of live MMR vaccine required. **Dose #1** administered on or after 1st birthday. **Dose #2** administered after 15 months of age and at least 28 days after 1st dose.	Dose #1 ___ /___ /___ MM DD YY	Dose #2 ___ /___ /___ MM DD YY		
MEASLES	If born on or after 1/1/57, two live doses required. **Dose #1** administered on or after 1st birthday. **Dose #2** administered after 15 months of age and at least 28 days after 1st dose.	Dose #1 ___ /___ /___ MM DD YY	Dose #2 ___ /___ /___ MM DD YY	Disease Date ___ /___ /___ MM DD YY	Serology Date ___ /___ /___ MM DD YY ☐ Immune
MUMPS	If born on or after 1/1/57, one live dose required. **Dose #1** administered on or after 1st birthday.	Dose #1 ___ /___ /___ MM DD YY	Disease Date ___ /___ /___ MM DD YY	Serology Date ___ /___ /___ MM DD YY ☐ Immune	
RUBELLA	If born on or after 1/1/57, one live dose required. **Dose #1** administered on or after 1st birthday.	Dose #1 ___ /___ /___ MM DD YY	Serology Date ___ /___ /___ MM DD YY ☐ Immune		
MENINGOCOCCAL VACCINE	One dose within past 10 years containing serogroups A, C, Y, W-135	Dose #1 ___ /___ /___ MM DD YY	Dose #2 ___ /___ /___ MM DD YY		
VARICELLA VACCINE	Two doses, disease date or serology.	Dose #1 ___ /___ /___ MM DD YY	Dose #2 ___ /___ /___ MM DD YY	Disease Date ___ /___ /___ MM DD YY	Serology Date ___ /___ /___ MM DD YY ☐ Immune
TETANUS, DIPTHERIA PERTUSSIS	One booster within last 10 years. A single dose of Tdap recommended for all students.	☐ Tdap ___ /___ /___ MM DD YY	☐ Td ___ /___ /___ MM DD YY		
POLIO VACCINE	Date primary series completed.	___ /___ /___ MM DD YY			
HEPATITIS B VACCINE	Series of 3 doses.	Dose #1 ___ /___ /___ MM DD YY	Dose #2 ___ /___ /___ MM DD YY	Dose #3 ___ /___ /___ MM DD YY	
HEPATITIS A VACCINE	Series of 2 doses.	Dose #1 ___ /___ /___ MM DD YY	Dose #2 ___ /___ /___ MM DD YY		
HPV	Series of 3 doses.	Dose #1 ___ /___ /___ MM DD YY	Dose #2 ___ /___ /___ MM DD YY	Dose #3 ___ /___ /___ MM DD YY	

MD SIGNATURE | **DATE (MM/DD/YY)**

MENINGITIS RESPONSE: IMPORTANT – THIS RESPONSE IS REQUIRED BY FLORIDA STATE LAW FOR ALL STUDENTS.

☐ Date of meningococcal immunization containing serogroups A, C, Y, W-135 within the past 10 years.

MONTH _____ DAY _____ YEAR _____

☐ I read or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will **not** obtain the immunization against meningococcal meningitis disease.

SIGNATURE OF STUDENT (REQUIRED) | **DATE (MM/DD/YY)**

SIGNATURE OF PARENT/GUARDIAN FOR MINOR (REQUIRED) | **DATE (MM/DD/YY)**

MEDICAL HISTORY

NAME OF STUDENT _____ DATE OF BIRTH (MM/DD/YYYY)

Please check box if you have ever had any of the following conditions.

INFECTIOUS DISEASE
- ☐ Chicken Pox
- ☐ Infectious Mononucleosis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tuberculosis
- ☐ Malaria

EYES, EARS, NOSE, THROAT
- ☐ Wear Glasses/Contact
- ☐ Other Visual Problems
- ☐ Hearing Loss/Deafness
- ☐ Seasonal Allergies
- ☐ Recurrent Sinus Infection
- ☐ Recurrent Ear Infection
- ☐ Recurrent Nose Bleeds

CARDIOPULMONARY
- ☐ Chest Pain with Exercise or Exertion
- ☐ Syncope or Near Syncope
- ☐ Excessive Exertional or Unexplained Shortness of Breath with Exercise
- ☐ Excessive Exertional or Unexplained Fatigue with Exercise
- ☐ Heart Murmur
- ☐ Elevated Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Heart Disease
- ☐ Heart Palpitations or Irregular beat
- ☐ Elevated Cholesterol
- ☐ Marfan Syndrome
- ☐ Congenital Heart Defect
- ☐ Asthma
- ☐ Pneumonia/Bronchitis

G-I
- ☐ Reflux/GERD
- ☐ Ulcer
- ☐ Pancreatitis
- ☐ Gall Bladder Disease
- ☐ Hepatitis Type: _____
- ☐ Hernia
- ☐ Rectal Bleeding
- ☐ Irritable Bowel
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Hemorrhoids

GENITOURINARY
- ☐ Cystitis/Bladder Infection
- ☐ Blood in Urine
- ☐ Kidney Infection
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Sexually Transmitted Infection

FEMALE
- ☐ Pelvic/Vaginal Infections
- ☐ Pregnancy
- ☐ Breast Lump
- ☐ Painful Periods
- ☐ Irregular Periods
- ☐ Heavy Flow
- ☐ Abnormal PAP Smear

MALE
- ☐ Testicular Lump
- ☐ Testicular Torsion
- ☐ Undescended/Absent Testicle
- ☐ Hydrocele or Varicocele

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Joint Injury
- ☐ Bone Fractures
- ☐ Scoliosis
- ☐ Back Pain/Problems
- ☐ Osgood-Schlatter
- ☐ Tendinitis
- ☐ Other Musculoskeletal Disorders

HEMATOLOGIC/ONCOLOGIC
- ☐ Anemia
- ☐ Sickle Cell Trait/Disease
- ☐ Leukemia/Lymphoma
- ☐ Hemophilia
- ☐ Immune Deficiency
- ☐ Cancer

NEUROLOGIC
- ☐ ADD/ADHD
- ☐ Seizure Disorder
- ☐ Migraine Headaches
- ☐ Tension Headaches
- ☐ Concussion
- ☐ Head Injury with Loss of Consciousness
- ☐ Other Neurological Disorders

SKIN
- ☐ Eczema
- ☐ Acne
- ☐ Hives
- ☐ Chronic Rash
- ☐ Tattoos/Piercings
- ☐ Other: _____

METABOLIC
- ☐ Diabetes Mellitus
- ☐ Thyroid Disorder

MENTAL/EMOTIONAL
- ☐ Anger Management
- ☐ Eating Disorder
- ☐ Drug/Alcohol Dependency/Abuse
- ☐ Depression
- ☐ Panic/Anxiety Disorder
- ☐ Trouble Sleeping
- ☐ Bipolar Disorder
- ☐ Mood Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Schizophrenia
- ☐ Deliberate Self Harm
- ☐ Previous Psychiatric Hospitalization
- ☐ Other: _____

OTHER
- ☐ Anaphylactic Reaction
- ☐ Serious Accident/Injury
- ☐ Loss of Paired Organ:
  - ☐ Kidney
  - ☐ Ovary
  - ☐ Eye
  - ☐ Testicle
  - ☐ Other: _____
- ☐ Other Important Medical History: _____

Do you use tobacco?
☐ No ☐ Yes – packs/day _____

Do you drink alcohol?
☐ No ☐ Yes – amount/week _____

ALLERGIES: ☐ None
- ☐ Allergic to medications
- ☐ Allergic to X-ray dyes
- ☐ Allergic to food/insects/environmental

Please list all:
_____
_____
_____

SURGERIES: ☐ None
- ☐ Appendectomy ☐ Hernia repair
- ☐ Mole Removal ☐ Ear Tubes
- ☐ Wisdom Teeth Extraction
- ☐ Tonsils/Adenoids
- ☐ Other: (specify below)

_____
_____
_____

MEDICATIONS (including vitamins and supplements):
☐ None
_____
_____
_____
_____
_____

Additional information you wish to share about your health:
_____
_____
_____
_____
_____
_____

FAMILY HISTORY

	Age	If Deceased, State of Health	Age of Death	Cause of Death
Father				
Mother				
Siblings				

Have any of your relatives ever had any of the following?	Yes	Relationship		Yes	Relationship
Alcoholism			Cancer		
Asthma, Hay Fever			Mental Illness		
Diabetes			Kidney Disease		
Sickle Cell Trait/Disease			Seizure Disorder		
Disability due to heart disease before age 50			Marfan syndrome		
Elevated Blood Pressure			Other (list):		
Other heart related diagnosis, cardiomyopathies, long QT syndrome, arrhythmias					

PHYSICAL EXAMINATION (PE)

TO BE COMPLETED, SIGNED AND DATED BY HEALTHCARE PROVIDER.

☐ MALE ☐ FEMALE

NAME | DATE OF BIRTH (MM/DD/YYYY) | GENDER

HEIGHT | WEIGHT | BLOOD PRESSURE | PULSE

SICKLE CELL SCREEN REQUIRED FOR ALL D1 ATHLETES Sickle Cell Screen Date: MONTH _____ DAY _____ YEAR _____

☐ Positive ☐ Negative

TUBERCULOSIS (TB) SCREEN - Required for all students.

1. Does the student have signs or symptoms of active TB disease ☐ YES (go to TB Test) ☐ NO (go to question 2)
2. Is the student a member of a high risk group, or an international student from a high risk country.
   ☐ YES (go to TB Test) ☐ NO (**STOP** No further screening needed)

TUBERCULIN SKIN TEST: (Mantoux only)

Date placed: ____/____/____ (MM/DD/YY) Date read: ____/____/____ (MM/DD/YY)

Result: ____mm of induration

Interpretation based on mm of induration and risk factors:

☐ Negative ☐ Positive (Chest X-ray required)

TB TEST OR

IGRA: (Specify method) ☐ QFT-G ☐ QFT-GIT ☐ T-SPOT

Date Tested: ____/____/____ (MM/DD/YY)

Result: ☐ Negative
☐ Indeterminate/Borderline (repeat in 6-8 weeks)
☐ Positive (Chest X-Ray required)

Chest X-Ray Date: ____/____/____ (MM/DD/YY) Result: ☐ Normal ☐ Abnormal (explain): _____

Treatment Plan (include information about INH therapy and duration of treatment): _____

CLINICAL EVALUATION	NORMAL	RECORD ABNORMAL FINDINGS
1. Appearance (Report evidence of Marfan Stigmata)		
2. Skin		
3. Head, Ears, Eyes, Nose, Hearing, Visual Acuity		
4. Mouth, Teeth, Gums		
5. Neck and Thyroid		
6. Lungs/Chest		
7. Breasts		
8. Heart (supine and standing)		
9. Pulses (simultaneous femoral and radial)		
10. Abdomen		
11. Genitalia		
12. Back/Spine		
13. Extremities/Musculoskeletal		
14. Neurologic		
15. Emotional/Psychological		
16. Paired Organ Anatomy/Function		
17. Other Findings		

18. Is this student cleared for full physical activity, including participation in intramural, club or intercollegiate sports and able to meet the physical and emotional demands of college life, including studying abroad?

☐ YES - Unlimited activity and fit for college ☐ NO - Limited activity Reason: _____

Additional Comments/Recommendations: _____

I have reviewed the medical history and immunizations, conducted the TB screen and examined the student noted above. The information on this physical form is accurate, full and complete to the best of my knowledge. (Please date your signature.)

SIGNATURE OF HEALTH CARE PROVIDER **DATE (MM/DD/YY)**

PRINT NAME OF HEALTH CARE PROVIDER **ADDRESS** **PHONE** **FAX**