LANCASTER BIBLE COLLEGE
CAPITAL SEMINARY & GRADUATE SCHOOL

Physical Examination Form

To be completed by your primary care physician and returned to the health office prior to your first day of classes. Athletes must have this completed yearly.

Please Print

Name: _____ _____ _____ Date of Birth_____
LAST FIRST M.I.

Height: _____ Weight: _____ BP: _____/_____

Corrected Vision:
Right 20/_____ Left 20/_____ Contact Lenses_____ Glasses_____

Abnormalities located below in the following systems:

Please circle any areas of abnormalities		
Head, Ears, Nose or Throat	Hernia	Metabolic/Endocrine
Eyes	Genitourinary	Skin
Respiratory	Musculoskeletal	Other:
Cardiovascular	Neuropsychiatric	
Gastrointestinal		

If any areas are circled, please explain below:

_____

_____

Allergies: Yes or No; If Yes, please list below
Medications: _____

Foods: _____

Environmental: _____

Does the student require a special diet? Yes or No If yes, please list diet: _____

Please list any medications:

_____

_____

List any pertinent surgeries/hospitalizations or injuries:

_____

_____

Clearance for Sports Participation: Participating in _____
_____ Cleared for full participation
_____ Cleared after completing the evaluation/rehabilitation for _____
_____ Not cleared/May not participate
_____ N/A

Is the patient under any treatment now for medical or emotional conditions? Please list:

_____

_____

(See other side)

Student's Full Name _____ **Date of Birth** _____/_____/_____

FOR FIRST YEAR STUDENTS ONLY: Record Immunizations:
Every item on this page must be completed by your primary care provider prior to attending class at Lancaster Bible College. An attached immunization record that include the required immunizations below is acceptable.

REQUIRED: Please provide dates

MMR (Measles, Mumps, Rubella)
First_____/_____/_____ Second_____/_____/_____
(Those born before 1957 are considered immune to measles, mumps and rubella)

Polio
First_____/_____/_____ Second_____/_____/_____ Third: _____/_____/_____ Latest Booster_____/_____/_____

Diphtheria, Tetanus, Pertussis
First_____/_____/_____ Second_____/_____/_____ Third: _____/_____/_____ Latest Booster_____/_____/_____

Meningococcal Vaccine: MUST BE COMPLETED - Failure to provide a record of meningococcal will result in being delayed in moving into a resident hall per PA Mandate. (www.immunize.org/laws/menin.asp)

Meningococcal Vaccine (Menactra/Menveo) First_____/_____/_____ Second _____/_____/_____
Meningitis B First _____/_____/_____ Second _____/_____/_____

Meningococcal Vaccine Pennsylvania State law provides that a student at an institute of higher education may not reside in a dormitory or campus housing unit unless the vaccination against meningococcal disease has been received, or a student (parent or guardian for minors) may sign a written waiver verifying they have chosen not to receive the meningococcal disease vaccination for religious or other reasons. Please review the links below for information and risk for meningitis. www.cdc.gov/meningococcal/about/risk-community.html www.cdc.gov/meningitis/bacterial.html Meningococcal Vaccine Meningitis B Vaccine (Menactra/Menveo) (Bexsero/Trumenba) OR Meningococcalwaiver:

I, (student's name printed) _____, received and reviewed the information provided by the above links regarding meningococcal disease or that the doctor has shared with me. I am fully aware of the risks associated with meningococcal disease and of the availability and effectiveness of the vaccinations against the disease. I wavier the meningococcal disease vaccine at this time.
(student's signature) _____

Other Recommended Vaccines:
Varicella: First_____/_____/_____ Second_____/_____/_____ or disease date _____/_____/_____
Hepatitis B: First_____/_____/_____ Second_____/_____/_____ Third: _____/_____/_____
HPV: First_____/_____/_____ Second_____/_____/_____ Third: _____/_____/_____

Provider's Name (Print) _____

Provider's Signature _____ License number _____

Practice Name _____

Office Address _____

Phone _____ Fax_____ Date _____