Jefferson Health®

Pre-Matriculation Physical Evaluation Form for Category B

January 1, 2021

Dear Incoming Jefferson Student:

To avoid unnecessary tests and costs, it is advisable that you understand your program's category assignment and complete the appropriate requirements.

Take this form to your healthcare provider. On the day of your visit, bring all of your previous immunization records and prior titer results to make your visit with your healthcare provider efficient and productive.

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

To Determine That This Is The Correct Form For Your Program, Read The Medical Record Requirements By Category Assignment. (Available on Occupational Health Network's Website)
Program you are entering (please include Program on all correspondence)

COLLEGES/PROGRAMS/DEGREES	Start Date	Expected Graduation Date
Write In Your College/Program/Degree below: **College Name:**		
Program:		
Degree:		

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 occupational Health Network 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:

If special accommodation is needed, contact:

Jennifer Fogerty, MSEd

Assistant Provost For Student Affairs

Jennifer.Fogerty@jefferson.edu

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.

Dear Healthcare Provider:

Please complete the following list of **REQUIREMENTS** listed on these pages and perform a physical examination (page 5) for our incoming student. **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 Occupational Health Network's website: https://hospitals.jefferson.edu/departments-and-services/occupational-health-network.html

Requirements:

1. MMR (Measles, Mumps, Rubella)

Measles/Mumps/Rubella Immunity as documented by a positive IgG antibody titer **(copy must be attached).**

- If equivocal or negative titer result for Measles, documentation of two MMR vaccines is needed (initial MMR series acceptable).
- If equivocal or negative titer result for Mumps, documentation of two MMR vaccines is needed (initial MMR series acceptable).
- If equivocal or negative titer result for Rubella, documentation of one MMR vaccine is needed (initial MMR series acceptable).

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**

2. Varicella (Chicken Pox)

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

Dose #1 Date: / /
Dose #2 Date: / /

OR

Varicella (IgG) antibodies titer Date: / /
Results: ☐ POS ☐ NEG ☐ EQUIV ☐ **Lab Report Attached**

3. Tetanus/Diphtheria/Pertussis (TDAP) - Recommended within 5 years of your start date.

Tetanus/Diphtheria/Pertussis Immunity as documented by a recent dose of the Tdap (tetanus/diphtheria/acellular pertussis) booster. Common brand names are Adacel and Boostrix. **Tetanus/diphtheria (Td) will NOT be accepted.**

Vaccine Date: / / man/lot/exp:

4. Hepatitis B Immunity

Hepatitis B Immunity as documented by 3 doses of the vaccine **&** positive Hepatitis B Surface Antibody titer **(copy must be attached).**

- If negative, receive 4th dose of the Hep B vaccine, repeat titer four weeks from the 4th dose.
- If repeat titer is positive, no further testing needed.
- If repeat titer is negative, continue with doses 5 & 6 as scheduled.

Primary Hepatitis B Series	Dose #1 Date: / /	**Secondary Hepatitis B Series** (If no response to primary series)	Dose #4 Date: / /
	Dose #2 Date: / /		Dose #5 Date: / /
	Dose #3 Date: / /		Dose #6 Date: / /
Hep B Surface Antibody Results:	Date: / / ☐ **Lab Report Attached**	Hep B Surface Antibody Results:	Date: / / ☐ **Lab Report Attached**

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

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

Requirements continue:

Hepatitis B Immunity (continue)		
♦ 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 must be performed.		
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**

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

6. Meningitis Vaccination	
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.	
Meningitis Vaccination	
Living in Jefferson Housing ☐ Yes ☐ No	Date of vaccine (If answered yes) _____ **OR** Date of declination _____

7. Influenza
Seasonal influenza vaccine is mandatory during Flu season (Aug - April)
♦ Influenza vaccine will be provided free of charge by Occupational Health Network (Center City) during the Fall semester. ♦ If received outside of OHN (Center City), documentation is required. Include the following: date of vaccination, manufacturer, lot number, expiration date, signature of administrator.
Vaccine Date: / / man/lot/exp:

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

Name (Print)	Date of Birth / /
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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:	