



# PHYSICAL EXAMINATION

*Physical examination must be within one year of entrance date.*

**Please note:**  
 “\*” indicates  
 required tests  
 and  
 immunizations

TO THE EXAMINING CLINICIAN. Please review the student’s history, complete the physical examination form, and comment on all positive answers.  
 Note: Do not omit the CBC or U/A tests as they are required. This student had been accepted. The information supplied will not affect status; it will be used only as a background for providing health care, if necessary. It is strictly for the use of Student Health Services, and will not be released without the student’s consent. This examination is at student expense.

Name \_\_\_\_\_ M [ ] F [ ] Date of Birth \_\_\_\_\_

|     |     |     |       |     |  |  |
|-----|-----|-----|-------|-----|--|--|
| Age | Wt. | Ht. | Pulse | B/P | *Urinalysis ( <b>required</b> )<br>Alb.____ Sug.____ Blood____ | *CBC ( <b>required</b> )<br>( <b>Attach report</b> ) |
|-----|-----|-----|-------|-----|--|--|

|                |                |         |                   |             |
|----------------|----------------|---------|-------------------|-------------|
| Contact Lenses | yes ___ no ___ | Vision: | Corrected _____   | R 20/ _____ |
| Glasses        | yes ___ no ___ |         | Uncorrected _____ | L 20/ _____ |

## CLINICAL EVALUATION

## REMARKS OR ADDITIONAL INFORMATION

| <b>Check each item in appropriate column, at right.<br/>Enter “N.E.” if not evaluated.</b>                                 | <b>Normal</b> | <b>Abnormal</b> |
|--|---------------|-----------------|
| 1. SKULL, SCALP, FACE, NECK, THYROID   |               |                 |
| 2. NOSE and SINUSES  |               |                 |
| 3. MOUTH (tongue, gingivae, teeth)   |               |                 |
| 4. THROAT and TONSILS  |               |                 |
| 5. EARS (Int. and Ext. Canals)   |               |                 |
| 6. EYES (pupils, E.O.M., conjunctiva)  |               |                 |
| 7. LUNGS and CHEST (include breasts)   |               |                 |
| 8. HEART (rhythm, sounds, murmurs. Examine in sitting, recumbent, and left recumbent positions before and after exercise.) |               |                 |
| 9. ABDOMEN and VISCERA (include hernia)  |               |                 |
| 10. ENDOCRINE SYSTEM   |               |                 |
| 11. G-U SYSTEM   |               |                 |
| 12. MUSCULOSKELETAL  |               |                 |
| 13. FEET (flat, pain, infection)   |               |                 |
| 14. SKIN   |               |                 |
| 15. LYMPHATIC GLANDS   |               |                 |
| 16. NEUROPSYCHIATRIC   |               |                 |

Medication Allergies/Food Allergies: \_\_\_\_\_

Summary of defects and diagnosis: \_\_\_\_\_

Do you have any recommendations regarding the care of this student? Yes \_\_\_ No \_\_\_

If yes, explain \_\_\_\_\_

Recommendations for physical activity in Physical Ed, Intramurals, Intercollegiate, or Club Sports:

Unlimited \_\_\_ Limited \_\_\_ No PE \_\_\_ Explain \_\_\_\_\_

Physician’s Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

Physician’s name (please print or use stamp) \_\_\_\_\_ FAX: \_\_\_\_\_

Address \_\_\_\_\_

**CERTAIN IMMUNIZATIONS ARE REQUIRED BY THE STATE OF ILLINOIS FOR ALL INCOMING COLLEGE STUDENTS.  
 PLEASE COMPLETE THE IMMUNIZATION AND TUBERCULOSIS SCREENING CERTIFICATE ON THE NEXT TWO PAGES.**

(continued)



Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**RECOMMENDED IMMUNIZATIONS**

**POLIO**

Recommended

|   |                               |                               |                               |                               |                               |
|---|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| OPV (oral)<br>Or<br>IPV (injected)<br><i>Indicate which one</i> | #1<br>_____<br>MONTH DAY YEAR | #2<br>_____<br>MONTH DAY YEAR | #3<br>_____<br>MONTH DAY YEAR | #4<br>_____<br>MONTH DAY YEAR | #5<br>_____<br>MONTH DAY YEAR |
|---|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|

**MENINGOCOCCAL**

**Recommended (One dose – preferably at entry into college for freshmen living in residence halls who wish to reduce their risk of meningococcal disease. Any student who wishes to reduce his/her risk of disease can consider the vaccine. Students with immunodeficiency such as complement deficiency or asplenia should receive vaccine every 3-5 yrs.)**

|   |                               |                               |
|---|-------------------------------|-------------------------------|
| *Please circle which vaccine given.<br>MENINGOCOCCAL<br>*MPSV4 (Menomune) <u>or</u> MCV4 (Menactra) | #1<br>_____<br>MONTH DAY YEAR | #2<br>_____<br>MONTH DAY YEAR |
|---|-------------------------------|-------------------------------|

**HEPATITIS B OR TWINRIX**

Recommended (Three doses of vaccine OR a positive Hepatitis surface antibody OR three doses of Twinrix)

|                              |                               |                               |   |  |                               |                               |
|------------------------------|-------------------------------|-------------------------------|---|--|-------------------------------|-------------------------------|
| IMMUNIZATION                 | #1<br>_____<br>MONTH DAY YEAR | #2<br>_____<br>MONTH DAY YEAR | #3<br>_____<br>MONTH DAY YEAR                 | TWINRIX<br>(Hepatitis A and Hepatitis B) |                               |                               |
| HEPATITIS B SURFACE ANTIBODY | _____<br>MONTH DAY YEAR       | _____<br>MONTH DAY YEAR       | RESULT:<br>____ REACTIVE<br>____ NON-REACTIVE | #1<br>_____<br>MONTH DAY YEAR            | #2<br>_____<br>MONTH DAY YEAR | #3<br>_____<br>MONTH DAY YEAR |

**VARICELLA**

Recommended (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 years)

HISTORY OF DISEASE YES \_\_\_\_\_ NO \_\_\_\_\_

|                    |                               |   |
|--------------------|-------------------------------|---|
| VARICELLA ANTIBODY | _____<br>MONTH DAY YEAR       | RESULT:<br>____ REACTIVE<br>____ NON-REACTIVE |
| IMMUNIZATION       | #1<br>_____<br>MONTH DAY YEAR | #2<br>_____<br>MONTH DAY YEAR                 |

**OTHER IMMUNIZATIONS RECEIVED (i.e. Hepatitis A, Typhoid, HPV, Yellow Fever, etc.)**

|  |                               |                               |                               |                               |                               |
|--|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
|  | #1<br>_____<br>MONTH DAY YEAR | #2<br>_____<br>MONTH DAY YEAR | #3<br>_____<br>MONTH DAY YEAR | #4<br>_____<br>MONTH DAY YEAR | #5<br>_____<br>MONTH DAY YEAR |
|  | #1<br>_____<br>MONTH DAY YEAR | #2<br>_____<br>MONTH DAY YEAR | #3<br>_____<br>MONTH DAY YEAR | #4<br>_____<br>MONTH DAY YEAR | #5<br>_____<br>MONTH DAY YEAR |
|  | #1<br>_____<br>MONTH DAY YEAR | #2<br>_____<br>MONTH DAY YEAR | #3<br>_____<br>MONTH DAY YEAR | #4<br>_____<br>MONTH DAY YEAR | #5<br>_____<br>MONTH DAY YEAR |
|  | #1<br>_____<br>MONTH DAY YEAR | #2<br>_____<br>MONTH DAY YEAR | #3<br>_____<br>MONTH DAY YEAR | #4<br>_____<br>MONTH DAY YEAR | #5<br>_____<br>MONTH DAY YEAR |

**THIS CERTIFICATE MUST BE SIGNED BY A HEALTH CARE PROVIDER.** (Physician, Nurse, or Health Department stamp)

Please return certificate to:  
Wheaton College Student Health Services  
501 E. College Ave Wheaton, IL 60187  
(630) 752-5072 phone • (630) 752-5575 fax

Required Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail \_\_\_\_\_ Address: \_\_\_\_\_

**Immunization Exemption Policy** (All religious or medical exemptions must be in writing on a separate sheet signed by a physician.):  
By Illinois State law, a student may be exempt from immunizations for one of only two reasons: medical or religious. Medical exemptions must be signed by a physician. Religious exemptions must include a signed statement from the student stating the exact reasons for the requested exemption. If student is a minor, the student must complete the statement with their signature and the signature of parent or guardian. Please note: further documentation and a review process will be necessary if exemption option is selected.