

**LANCASTER GENERAL COLLEGE OF NURSING AND HEALTH SCIENCES  
PHYSICAL EXAM AND IMMUNIZATION RECORD**

In order to enter Lancaster General College and participate in clinical experiences, this entire form must be completed. **This form is ONLY required at your entry into the college.** Please use the annual physical form in Blackboard for subsequent years.

Student Name: \_\_\_\_\_ Program of Study: \_\_\_\_\_

IMMUNIZATIONS: Please list DATES and RESULTS as requested:

1. Diphtheria/Tetanus (date of last injection must be within past **ten** years ): \_\_\_\_\_

2. Hepatitis B (first inoculation required prior to start of semester. Proof of series completion should be forwarded to the College Health Center). Any student who chooses not to receive the series or who cannot supply dates of immunization must sign a waiver accepting responsibility for potential exposure to Hepatitis B. Partial completion of a series requires that a Hepatitis B surface antibody test be completed. A non-reactive result may result in the need to re-start the series or sign a waiver.

#1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

3. Antibody Titres (**blood test**):

a. Varicella:	Date: _____	Antibody result: _____
b. Rubella:	Date: _____	Antibody result: _____
c. Rubeola:	Date: _____	Antibody result: _____
d. Mumps:	Date: _____	Antibody result: _____

**\*\*\*Blood work must be completed regardless of whether you have had the disease or have been immunized in the past. If titres are negative or equivocal, you must receive immunization from your health care provider\*\*\***

4. Current Medications:

Please list any prescription medications that you take on a regular basis: \_\_\_\_\_

\_\_\_\_\_

5. Do you require accommodation for a physical or mental disability? \_\_\_\_\_.

**\*\* If you answered yes, please contact Elaine Neidert, Health Coordinator, directly for assistance @ 717 544-5354 or [emneider@lancastergeneralcollege.edu](mailto:emneider@lancastergeneralcollege.edu)\*\***

In your opinion as a clinician, is there any reason that the applicant, \_\_\_\_\_ may not be successful in their program?

\_\_\_ no

\_\_\_ yes (please explain below)

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**PHYSICAL EXAM**

SYSTEM	WNL	COMMENTS
<b>HEENT</b> (please include visual acuity)		
<b>Skin</b>		
<b>Cardiovascular</b>		
<b>Respiratory</b>		
<b>Abdomen/GI</b>		
<b>Musculoskeletal</b>		
<b>Neurological</b>		
<b>Genitourinary</b>		
<b>Oral Cavity/Gums</b>		
PPD Test:	Date Read: Result:	If positive, date of CXRAY: Result: Isoniazid RX: yes: __ date: _____ No: __

Physician/NP/PA Signature: \_\_\_\_\_ (printed name) \_\_\_\_\_  
Date: \_\_\_\_\_