



Lancaster General
College of Nursing
& Health Sciences

ENTRY PHYSICAL EXAM AND IMMUNIZATION RECORD

In order to enter Lancaster General College and participate in clinical experiences, this entire form must be completed.

Student Name: _____ Program of Study: _____

Birthdate: _____

Emergency Contact Name _____ Phone Number _____

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IMMUNIZATIONS: Please list DATES and RESULTS as requested:

1. Date of last Diptheria/Tetanus: _____ or Tetanus Diptheria & Pertussis TDaP (preferred) _____ (must be within past 10 years).

2. Hepatitis B (first inoculation required prior to start of semester) or a positive HBsAB (lab test). Proof of series completion should be forwarded to the Employee/Student Health). Any student who chooses not to receive the series must sign a waiver.

#1 _____ #2 _____ #3 _____

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

a. Rubella IgG: Date: _____ Antibody result: _____

4. Proof of 2 MMR's Date _____ and _____ or

a. Rubeola IgG: Date: _____ Antibody result: _____

b. Mumps IgG: Date: _____ Antibody result: _____

5. Proof of 2 Varicella Vaccinations Date _____ and _____ or

a. Varicella IgG Date _____ Antibody result: _____

***** 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:

*If taking a narcotic medication please have physician/NP note he/she has reviewed your student responsibilities and feels you can safely perform clinical while taking this medication.

5. Do you require accommodation for a physical, mental or learning disability? _____.

**** If you answered yes, please contact the Employee/Student Health Office at 717-544-5984.**

PHYSICAL EXAM

| SYSTEM | WNL | COMMENTS |
|--|------------|-----------------|
| HEENT (please include visual acuity) | | |
| Skin | | |
| Cardiovascular | | |
| Respiratory | | |
| Abdomen/GI | | |
| Musculoskeletal | | |
| Neurological | | |
| Genitourinary | | |
| Oral Cavity/Gums | | |
| | | |

Physician/NP/PA Signature: _____ (printed name) _____
 Date: _____

Student Health Clearance

(To be completed by Health Care provider)

I, _____, hereby certify that _____,
 (provider) (student)

is able to perform the necessary functions associated with a beginning health care provider and student while attending college, regardless of any current physical/mental health condition or regularly prescribed medication use. He/she is enrolled in the _____ program.

Date: _____ Signature: _____