MUHLENBERG COLLEGE HEALTH SERVICES  
2400 CHEW STREET • ALLENTOWN, PA 18104 • 484-664-3199

PHYSICIAN’S REPORT OF HEALTH EVALUATION

TO THE EXAMINING PHYSICIAN: Please review the student’s history and complete the physician’s report. Please comment on all positive answers. This student has been accepted. The information supplied will not affect his/her status. It will be used only as a background for providing health and mental health care. This information is strictly for the use of the Health Services & Counseling Services and is not released without student consent. **Physical Exam must be done within 6 months prior to college entrance.**

**LAST NAME (Print) **| **FIRST NAME **| **MIDDLE **| **SEX:** M ☐ F ☐
---|---|---|---
**B/P** | **P** | **Height** | in. | **Weight** | lbs | **URINALYSIS:** | **Sugar** | **Albumin**
**VISUAL ACUITY:** | **R** | **/** | **L** | **/** | Corrected: Y N |

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal – Please Describe</th>
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Skin | |
Head and Scalp | |
Eyes | |
Ears/Hearing | |
Mouth, Nose, Throat | |
Neck | |
Heart | |
Lungs | |
Abdomen | |
Genitourinary | |
Musculoskeletal | |
Neurologic | |
Emotional | |

Have you any general comments? _______________________________________________________________________________

Is there loss or seriously impaired function of any paired organ? _____Yes _____ No

Recommendations for physical activity (PE, Intramurals): Unlimited _______ Limited _____ Explained: _______________

Is the patient now under treatment for any medical or psychological condition? Yes _____ No _____

If yes, please explain: _________________________________________________________________________________

Do you have any recommendations regarding the care of this student, not previously addressed? Yes _____ No _____

If yes, please explain: _________________________________________________________________________________

**TUBERCULOSIS SCREENING**

1. Does the student have signs or symptoms of active tuberculosis disease? ☐ Yes ☐ No

If NO, proceed to #2. If YES, proceed with additional evaluation to exclude active tuberculosis disease, including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

2. Is the student a member of a high-risk group*? ☐ Yes ☐ No

If NO, stop. If Yes, PPD (Mantoux) required; proceed to #3. A HISTORY OF BCG VACCINATION SHOULD NOT PRECLUDE TESTING A MEMBER OF A HIGH RISK GROUP.

*Please see PREADMISSION IMMUNIZATION POLICY (Page 3 of Health Form) for categories of high risk.

3. Tuberculin Skin Test (PPD):
   **Date given (within the 6 months of college entrance) __________________**  **Date Read __________________**
   Result: _________ (record actual mm of induration) ☐ Positive ☐ Negative

4. CHEST X-RAY REQUIRED if tuberculin skin test is positive.
   **Chest X-Ray result:** ☐ Normal ☐ Abnormal  **X-ray Date:** __________________
   **Referral to State Health Department:** ☐ Yes ☐ No  **INH given:** ☐ Yes ☐ No  **If Yes, give dates __________________________

Date: __________________________  Health Care Provider Signature: ______________________________________________________________________________________
Health Care Provider Name & Address: ______________________________________________________________________________________________________________________
Provider Telephone Number: __________________________________________________________________Fax Number: __________________________