University of Evansville

INSTRUCTIONS

Do Not Upload This Page

University: **University of Evansville - Doctor of Physical Therapy**

Student: _____ DOB: _____

☑ HOW TO COMPLETE THESE FORM(S):

- ☐ A licensed healthcare professional **MUST** complete and sign **THESE** forms. **All green sections are required.**
- ☐ **Other forms of health records containing the required health information will be accepted.**
- ☐ **PRINT CLEARLY WITH DARK BLACK INK.** A computer will be reading your forms. Fill in circles completely.
- ☐ Do not fold, cut, or mark on the border lines of these forms.
- ☐ Include the Border Lines in your scanned images.
- ☐ Review your forms for completeness and accuracy. Double check **ALL** signatures. **MM/DD/YY date formats.**
- ☐ Consult your Healthcare Professional before receiving any of the following immunizations.

Your records are due by: April 1.

REQUIRED

Required by regulation and/or policy to attend required clinical education in this university's DPT program.

Documents:

Immunization Certificate (see page 2)
Physical Exam (see page 3)

Immunization Dates:

Varicella (2 doses OR Pos. Titer)
Hepatitis B (3 doses)
COVID one completed series (Req. for clinical sites)
TDaP Booster (1 dose within last 10 yrs)
MMR (2 doses OR Pos. Titer)
Meningococcal (21 years of age or younger require 1 dose @ age 16 or older)

TB Test:

Results must be performed and read in U.S. & within 6 months of the start of the semester.

RECOMMENDED

Recommended for your general well being but NOT required.

Immunization Dates:

Polio
Hepatitis A
HPV
Meningococcal B

OPTIONAL

Optional information.

Immunization Dates:

Pneumococcal
JE - Japanese Encephalitis Typhoid
Yellow Fever
Rabies

☑ UPLOADING YOUR FORM(S):

- ☐ Review your forms for completeness and accuracy. **Double check ALL signatures.**
- ☐ Scan or photograph your documents as JPGs for upload. Be sure to include the border lines and fill the picture frame.
- ☐ Upload your completed forms to your account at medproctor.com. **(Pages 2&3)**
- ☐ You may upload your additional documentation for storage and later retrieval. (blue cards, state records, etc.)
- ☐ Check your University Email account regularly for messages from MedProctor regarding incomplete information.

You will be notified via email once your information is successfully verified.

BE AWARE:

* Incomplete/illegible writing and poor images will be rejected.
* Completion of these forms by your due date will help expedite your registration process.

Should you require medical/religious exemptions, please contact UE Student Health Center at 812-488-2033 or email healthcenter@evansville.edu

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IMMUNIZATION CERTIFICATE

PRINT CLEARLY WITH DARK BLACK INK.
Must be completed by a healthcare professional.
This form will be read by a computer.
Upload to medproctor.com

Green = Required
Blue = Recommended
Black = Optional

University: **University of Evansville - Doctor of Physical Therapy**

Student: _____ DOB: _____

TDaP - Booster — Required
Within 10 yrs. M M D D Y Y

MMR Measles, Mumps, Rubella — Required
1st M M D D Y Y
2nd M M D D Y Y

MENINGOCOCAL — Required
1st M M D D Y Y
2nd M M D D Y Y

MENINGOCOCAL B — Recommended
1st M M D D Y Y
2nd M M D D Y Y

HEPATITIS B — Required
1st M M D D Y Y
2nd M M D D Y Y
3rd M M D D Y Y

COVID — Required for clinical sites
1st M M D D Y Y
2nd M M D D Y Y
3rd optional M M D D Y Y

HPV Human Papillomavirus — Recommended
1st M M D D Y Y
2nd M M D D Y Y
3rd M M D D Y Y

VARICELLA - Chicken Pox — Required
1st M M D D Y Y
2nd M M D D Y Y

HEPATITIS A — Recommended
1st M M D D Y Y
2nd M M D D Y Y

POLIO - Inactivated — Recommended
1st M M D D Y Y
2nd M M D D Y Y
3rd M M D D Y Y
4th M M D D Y Y

TYPHOID - Inactivated — Optional
One M M D D Y Y

YELLOW FEVER — Optional
One M M D D Y Y

RABIES - Pre-Exposure — Optional
1st M M D D Y Y
2nd M M D D Y Y
3rd M M D D Y Y

REQUIRED - Immunization History Signature (Please clearly complete ALL and place office stamp at bottom of page.)

LICENSED CARD PROFESSIONAL SIGNATURE NON-PARENTAL	PRINT LICENSED HEALTH CARE PROFESSIONAL FIRST AND LAST NAME	SIGNATURE DATE
		__ __ __ __ __ __

NPI NUMBER *not required for U.S. service members or international students*	NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL	OFFICE PHONE NUMBER
__ __ __ __ __ __ __ __ __ __		__ __ __ – __ __ __ – __ __ __ __

REQUIRED - Tuberculosis Skin or Blood Test Results

TB Skin PPD

Placed: M M D D Y Y
Read: M M D D Y Y

actual induration in MM only __ __

mm and range REQUIRED (fill bubble)

- 0 mm
- 0 to < 5 mm
- 5 to < 10 mm
- 10 to < 15 mm
- 15 mm or larger

OR

TB Blood T-Spot QuantiFERON

Test M M D D Y Y

Results
- Positive
- Negative

REQUIRED - Tuberculosis Test Results Signature (Please clearly complete ALL and place office stamp at bottom of page.)

LICENSED CARD PROFESSIONAL SIGNATURE NON-PARENTAL	PRINT LICENSED HEALTH CARE PROFESSIONAL FIRST AND LAST NAME	SIGNATURE DATE
		__ __ __ __ __ __

NPI NUMBER *not required for U.S. service members or international students*	NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL	OFFICE PHONE NUMBER
__ __ __ __ __ __ __ __ __ __		__ __ __ – __ __ __ – __ __ __ __

OFFICE STAMP
(Not required if stamp unavailable.)

University of Evansville

PHYSICAL EXAMINATION

PRINT CLEARLY WITH DARK BLACK INK.
Must be completed by a healthcare professional.
This form will be read by a computer.
Upload to medproctor.com

Hearing test and hct/hgb are NOT required

University: **University of Evansville - Doctor of Physical Therapy**

Student: _____ DOB: _____

PLEASE NOTE:

This form must be completed clearly and signed by a Physician, Nurse Practitioner or Physician Assistant.
Provider, please take a moment to counsel the future college student on lifestyle and social issues associated with the college experience.

Height: __ __ **inches** Temp: __ __ __ Pulse: __ __ __
Weight: __ __ __ __ **pounds** BP: __ __ __ / __ __ __

This section is optional.
Hearing: Gross Right ○ Pass ○ Fail Left ○ Pass ○ Fail
Hearing: 15 ft. Right ○ Pass ○ Fail Left ○ Pass ○ Fail

Vision: Corrected: Right 20/__ __ Left 20/__ __
Uncorrected: Right 20/__ __ Left 20/__ __

This section is optional.
Hgb: __ __ __ OR Hct: __ __ %

			EXPLAIN ABNORMALITIES
General Appearance	○ NORMAL	○ ABNORMAL	
Head, Ears, Nose, Throat, Neck	○ NORMAL	○ ABNORMAL	
Eyes	○ NORMAL	○ ABNORMAL	
Respiratory	○ NORMAL	○ ABNORMAL	
Cardiovascular	○ NORMAL	○ ABNORMAL	
Mammary	○ NORMAL	○ ABNORMAL	
Gastrointestinal	○ NORMAL	○ ABNORMAL	
Hernia	○ NORMAL	○ ABNORMAL	
Genitourinary	○ NORMAL	○ ABNORMAL	
Musculoskeletal	○ NORMAL	○ ABNORMAL	
Metabolic/Endocrine	○ NORMAL	○ ABNORMAL	
Neuropsychiatric	○ NORMAL	○ ABNORMAL	
Skin	○ NORMAL	○ ABNORMAL	

Is there loss or seriously impaired function of any organ? ○ No ○ If yes
Explain:

Is the student under treatment for any medical or emotional condition? ○ No ○ If yes
Explain:

Recommendation for physical activity (physical education, intramurals, etc)? ○ Unlimited ○ If Limited
Specify limitations:

Is student physically mentally and emotionally healthy? ○ YES ○ If no
Explain:

NOTES:

REQUIRED - Physical Examination Signature (Please place office stamp at bottom of page.)

LICENSED CARD PROFESSIONAL SIGNATURE	PRINT LICENSED HEALTH CARE PROFESSIONAL FIRST AND LAST NAME	SIGNATURE DATE
NON-PARENTAL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __	__ __ __ __ __ __

NPI NUMBER *not required for U.S. service members or international students*	NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL	OFFICE PHONE NUMBER
__ __ __ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __	__ __ __ – __ __ __ – __ __ __ __

OFFICE STAMP
(Not required if stamp unavailable.)