

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	RECOMMENDED	OPTIONAL
<p>Required by regulation and/or policy to attend required clinical education in this university's DPT program.</p> <p>Documents: Immunization Certificate (see page 2) Physical Exam (see page 3)</p> <p>Immunization Dates: Varicella (2 doses OR Pos. Titer) Hepatitis B (3 doses) COVID (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)</p> <p>TB Test: Results must be performed and read in U.S. & within 6 months of the start of the semester.</p>	<p>Recommended for your general well being but NOT required.</p> <p>Immunization Dates: Polio Hepatitis A HPV Meningococcal B</p>	<p>Optional information.</p> <p>Immunization Dates: Pneumococcal JE - Japanese Encephalitis Typhoid Yellow Fever Rabies</p>

✓ 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

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TDaP - Booster Required

Within 10 yrs. 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

VARICELLA - Chicken Pox Required

1st M M D D Y Y

2nd M M D D Y Y

TYPHOID - Inactivated Optional

One 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

COVID Required for clinical sites

1st M M D D Y Y

2nd M M D D Y Y

3rd M M D D Y Y

HEPATITIS A Recommended

1st M M D D Y Y

2nd M M D D Y Y

YELLOW FEVER Optional

One M M D D Y Y

MENINGOCOCCAL Required

1st M M D D Y Y

2nd 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

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

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

MENINGOCOCCAL B Recommended

1st M M D D Y Y

2nd 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	PRINT LICENSED HEALTH CARE PROFESSIONAL FIRST AND LAST NAME	SIGNATURE DATE
NON-PARENTAL	_____	_____
NPI NUMBER <small>not required for U.S. service members or international students</small>	NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL	OFFICE PHONE NUMBER
_____	_____	____-____-____

REQUIRED - Tuberculosis Skin or Blood Test Results

<p>TB Skin PPD</p> <p>Placed: <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/> Y <input type="checkbox"/> Y</p> <p>Read: <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/> Y <input type="checkbox"/> Y</p> <p>actual induration in MM only _____</p>	<p>mm and range REQUIRED (fill bubble)</p> <p><input type="radio"/> 0 mm</p> <p><input type="radio"/> 0 to < 5 mm</p> <p><input type="radio"/> 5 to < 10 mm</p> <p><input type="radio"/> 10 to < 15 mm</p> <p><input type="radio"/> 15 mm or larger</p>	<p>OR</p> <p>TB Blood T-Spot QuantIFERON</p> <p>Test <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/> Y <input type="checkbox"/> Y</p> <p>Results</p> <p><input type="radio"/> Positive</p> <p><input type="radio"/> Negative</p>
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REQUIRED - Tuberculosis Test Results Signature (Please clearly complete ALL and 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 <small>not required for U.S. service members or international students</small>	NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL	OFFICE PHONE NUMBER
_____	_____	____-____-____

OFFICE STAMP
(Not required if stamp unavailable.)





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

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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: ___ / ___	<p style="text-align:center; color:red; font-size:small;">This section is optional.</p> Hearing: Gross Right <input type="radio"/> Pass <input type="radio"/> Fail Left <input type="radio"/> Pass <input type="radio"/> Fail Hearing: 15 ft. Right <input type="radio"/> Pass <input type="radio"/> Fail Left <input type="radio"/> Pass <input type="radio"/> Fail
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Vision: Corrected: Right 20/___ Left 20/___ Uncorrected: Right 20/___ Left 20/___	<p style="text-align:center; color:red; font-size:small;">This section is optional.</p> Hgb: ___ OR Hct: ___ %
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EXPLAIN ABNORMALITIES

General Appearance	<input type="radio"/> NORMAL	<input type="radio"/> ABNORMAL	
Head, Ears, Nose, Throat, Neck	<input type="radio"/> NORMAL	<input type="radio"/> ABNORMAL	
Eyes	<input type="radio"/> NORMAL	<input type="radio"/> ABNORMAL	
Respiratory	<input type="radio"/> NORMAL	<input type="radio"/> ABNORMAL	
Cardiovascular	<input type="radio"/> NORMAL	<input type="radio"/> ABNORMAL	
Mammary	<input type="radio"/> NORMAL	<input type="radio"/> ABNORMAL	
Gastrointestinal	<input type="radio"/> NORMAL	<input type="radio"/> ABNORMAL	
Hernia	<input type="radio"/> NORMAL	<input type="radio"/> ABNORMAL	
Genitourinary	<input type="radio"/> NORMAL	<input type="radio"/> ABNORMAL	
Musculoskeletal	<input type="radio"/> NORMAL	<input type="radio"/> ABNORMAL	
Metabolic/Endocrine	<input type="radio"/> NORMAL	<input type="radio"/> ABNORMAL	
Neuropsychiatric	<input type="radio"/> NORMAL	<input type="radio"/> ABNORMAL	
Skin	<input type="radio"/> NORMAL	<input type="radio"/> 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.)

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NON-PARENTAL		
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