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CALDWELL, NJ 07006-6195  
(973) 618-3319  
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<http://www.caldwell.edu>

Health Services \_\_\_\_\_

**PHYSICAL EXAMINATION FORM**  
**Full-Time Student**

**Please check:**

- Adult Undergraduate**  
 **Graduate**

**DUE DATE:**

Fall Semester Entry **July 15**  
Spring Semester Entry **December 15**

Please read carefully and complete **ALL** sections. Return form to Health Services at above address by due date. Incomplete forms will be returned to applicant and will jeopardize admittance to class and the residence halls.

**STUDENT SECTION**

**PLEASE PRINT**

Name: \_\_\_\_\_  
Last First Middle

Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ M ( ) F ( ) Age: \_\_\_\_\_ Student ID# (if known): \_\_\_\_\_  
Month Day Year

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

**PERSON TO CONTACT IN CASE OF EMERGENCY:**

**Primary Contact: (next of kin)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Daytime Phone: (\_\_\_\_\_) \_\_\_\_\_ Evening Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

**Secondary Contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Daytime Phone: (\_\_\_\_\_) \_\_\_\_\_ Evening Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

**CONSENT/ AUTHORIZATION:**

In case of illness or injury, permission is hereby granted to treat the student named below at Caldwell College Health Services, and to make the necessary referrals to private physicians or community facilities as indicated. All information contained within this form (except immunization records) will remain confidential and will be released only on written permission by the student.\*

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

**MEDICAL HISTORY** (to be completed by student)

Indicate below. If you have ever experienced any of these problems, please circle "Yes" ; if never, please circle "No". If you are currently experiencing any of these problems, please circle "Currently".

EYE				URINARY			
Corrective Lenses/Contacts	No	Yes	Currently	Kidney Stones	No	Yes	Currently
Other Problems	No	Yes	Currently	Urinary Tract Infection	No	Yes	Currently
Other Remarks _____				Other Remarks _____			
_____				_____			

ENT				MUSCULOSKELTETAL			
Ear Problems	No	Yes	Currently	Back Problems	No	Yes	Currently
Other Remarks				Disease or Injury of Joints	No	Yes	Currently
Other Remarks _____				Other Remarks _____			
_____				_____			

HEART DISEASE				HEMATOLOGICAL/ONCOLOGICVAL			
High Blood Pressure	No	Yes	Currently	Anemia	No	Yes	Currently
Palpitations	No	Yes	Currently	Cancer	No	Yes	Currently
Heart Murmur	No	Yes	Currently	Other Remarks _____			
Other Remarks _____				_____			
_____				_____			

RESPIRATORY				NEUROLOGICAL/PSYCHOLOGICAL			
Shortness of Breath	No	Yes	Currently	Seizures	No	Yes	Currently
Asthma	No	Yes	Currently	Headaches	No	Yes	Currently
Bronchitis	No	Yes	Currently	Depression	No	Yes	Currently
Other Remarks				Anxiety	No	Yes	Currently
Other Remarks _____				Eating Disorders	No	Yes	Currently
_____				Other Remarks _____			
_____				_____			

ABDOMINAL				GYNECOLOGICAL			
Irritable Bowel Syndrome	No	Yes	Currently	Irregular Periods	No	Yes	Currently
Inflammatory Bowel Disease	No	Yes	Currently	Severe Cramps	No	Yes	Currently
Other Remarks _____				Ovarian Cyst	No	Yes	Currently
_____				Other Remarks _____			
_____				_____			

ENDOCRINE				DISEASE HISTORY			
Diabetes	No	Yes	Currently	Chicken Pox:	No	Yes	Year: _____
Thyroid	No	Yes	Currently	Mononucleosis:	No	Yes	Year: _____
Other Remarks _____				Other Remarks _____			
_____				Allergies: _____			
_____				_____			
_____				_____			

FAMILY HISTORY- Circle all that apply					
<u>Mother</u>			<u>Father</u>		
Living	Deceased	High Blood Pressure	Living	Deceased	High Blood Pressure
Cancer	Diabetes	Thyroid Disease	Cancer	Diabetes	Thyroid Disease
	Heart Disease			Heart Disease	

Name: \_\_\_\_\_  
Last First

**Caldwell College Health Services**

**PHYSICAL**

**TO THE EXAMINING CLINICIAN:**

BP	/	Height		Weight	
<b>PHYSICAL EXAM:</b>					
Eyes		WNL	Remarks:		
Ears		WNL	Remarks:		
Nose		WNL	Remarks:		
Throat		WNL	Remarks:		
Neck		WNL	Remarks:		
Lungs		WNL	Remarks:		
Heart		WNL	Remarks:		
Abdomen		WNL	Remarks:		
Lymph glands		WNL	Remarks:		
G.U.		WNL	Remarks:		
Skin		WNL	Remarks:		
Neuro		WNL	Remarks:		
Musculoskeletal		WNL	Remarks:		

Current Medications: (including OTCs, birth control pills, etc.) \_\_\_\_\_

Allergies: \_\_\_\_\_

Does student have any physical/mental disability or condition which should limit participation in (check all that apply)

- Campus Residency    Classroom Activities    Physical Education    Competitive Sports

If yes, please explain: \_\_\_\_\_

Has student received treatment or counseling for a psychiatric condition, personality disorder or emotional problem?

If yes, please explain: \_\_\_\_\_

Physician's Name (please print) \_\_\_\_\_

Address \_\_\_\_\_

Phone# \_\_\_\_\_ Fax# \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date of completed exam \_\_\_\_\_





Dear Student:

The Health Services Department would like to inform you about a serious health hazard facing college students. This is the growing threat of meningitis on college campuses across the country.

Meningitis is a rare but potentially fatal disease with early symptoms that resemble the flu, making diagnosis difficult. The symptoms include high fever, severe headache, stiff neck, confusion, nausea and vomiting, exhaustion and/or a rash. If not treated early, meningitis can lead to severe and permanent disabilities, even death.

Meningococcal bacteria are transmitted through air droplets and by direct contact with infected persons. It occurs most often in late winter and early spring-when most college students are away at school. Cases of meningitis among teens and young adults 15-24 years of age-the age of most college students-have more than doubled since 1991. It is estimated that between 100-125 meningitis cases occur on college campuses each year and as many as 15 students will die from the disease.

While the reason for this rise in college campus outbreaks is not fully understood, studies suggest that college students are more susceptible because they live and work in close proximity to each other in dormitories and classrooms. Life style appears to be a risk factor as well, with exposure to active and passive smoking, alcohol consumption, and bar patronage all increasing the chances of contracting meningitis from an infected individual.

A vaccine is available that protects against four of the five strains of the bacteria that causes meningitis in the United States. These types account for nearly two-thirds of meningitis cases among college students. New Jersey State Law requires any student planning to live in campus housing **must** have a meningitis vaccine prior to moving into housing. In addition, the American College Health Association (ACHA) recommends that all other college students consider vaccination against meningitis to protect them against this serious disease.

In support of this recommendation, you are encouraged to discuss meningitis with your physician and consider vaccination prior to your college entrance.

Sincerely,

Karen Mullin, R.N., C.

# Meningitis Survey

**Please complete the survey below and return to Health Services in the enclosed envelope *along with your completed health records:***

***Please note: STUDENTS RESIDING IN CAMPUS HOUSING must complete #1, all other students must choose between statements 1-4.***

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I acknowledge that I have received and read the information about meningitis and the meningitis vaccine.

Please check one:

1. I have received the meningitis vaccine on \_\_\_\_\_.  
(date)
2. I have decided to receive the meningitis vaccine at a later date. \_\_\_\_\_
3. I have decided not to receive the meningitis vaccine. \_\_\_\_\_
4. I am undecided about whether or not to receive the meningitis vaccine. \_\_\_\_\_

Student's Name: \_\_\_\_\_ Date \_\_\_\_\_  
(Please print)

Signature: \_\_\_\_\_  
(If student is under 18 years of age, parent/guardian signature is required)