University of Evansville

INSTRUCTIONS

Do Not Upload This Page

University: **University of Evansville - general population**

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: July 1st for Fall Semester and December 1st for Spring Semester.

REQUIRED

Required by regulation and/or policy to attend this university.

Documents:

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

Immunization Dates:

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:

Varicella
Polio
Hepatitis A
Hepatitis B
HPV
Meningococcal B
COVID

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 - general population**

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 — Recommended
1st M M D D Y Y
2nd M M D D Y Y
3rd 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

COVID — 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 — Recommended
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 - general population**

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.)