Physical Examination for Cornell College (*To be completed by MD, DO, NP or PA)*

To the Examiner: Please review the student's report and complete this physical exam form with comments on all positive answers. Since this student has already been accepted for admission, the information supplied will not affect his or her status and will be used only as background for providing any needed care by Cornell College Student Health Services.
The completed form should be given to the student, who will return it to Health Services as instructed!

Patient's Name _____
Last *First* *Middle*

Birthdate _____ Assigned sex at birth *Male Female* Gender Identity (circle one) *M F N T*

BP _____ Pulse_____ Height_____ Weight_____ Vision _____

ALL athletes must be screened for sickle cell trait, show proof of a prior test, or sign a waiver on arrival on campus releasing Cornell athletics from liability if decline to be tested.
Sickle Cell Solubility Test/Screen (if indicated) _____ Screening declined _____

Are there any abnormalities of the following systems?

	No	Yes	Describe
Eyes			
Head, ENT			
Cardiovascular			
Respiratory			
Breast			
Gastrointestinal			
Genitourinary			
Hernia			
Musculoskeletal			
Metabolic/Endocrine			
Skin			
Neuropsychiatric			

Does the student have any concerns about their sleep quality or quantity? _____
Were any sleep issues addressed today? _____
How long have you known the student?_____

ALLERGIES TO MEDICATIONS: _____
CURRENT MEDICATIONS:
1)_____ 2)_____ 3) _____
4)_____ 5)_____ 6)_____

Recommendations for physical activity (P.E., intramurals or varsity athletics) □ Unlimited □ Limited Explanation_____ _____

Do you have any recommendations regarding the care of this student? □ Yes □ No If so, what?_____ _____

Is the patient now under treatment for any medical condition? □ Yes □ No Diagnosis_____ _____

Is the patient now under treatment for any emotional condition? □ Yes □ No Diagnosis_____ _____

General comments:_____

Provider's Signature_____

Date _____

Phone_____

Provider's Clinic Stamp Here:

Tuberculosis (TB) Risk Assessment : *Name:*_____ *Birthdate*_____

To be completed by your healthcare provider. Persons with any of the following are candidates for either Mantoux tuberculin skin test or Interferon Gamma Release Assay, unless a previous positive test has been documented.
Persons with no known risk factors should complete this form, but DO NOT need testing.

Risk Factors		
Recent close contact with someone with infectious TB disease	☐ Yes	☐ No
Foreign-born from, or travel to endemic region (Africa, Asia, Russia, Eastern Europe, Central or South America)	☐ Yes	☐ No
Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Organ transplant recipient	☐ Yes	☐ No
Immunosuppressed (equivalent of >15mg/day of prednisone for > 1 month, or TNF-a antagonist)	☐ Yes	☐ No
History of illicit drug use	☐ Yes	☐ No
Resident, employee, or volunteer in a high-risk congregate setting (e.g. correctional facilities, nursing homes, homeless shelters, hospitals, etc.)	☐ Yes	☐ No
Medical condition associated with increased risk of progressing to TB disease if infected - list name of disease_____	☐ Yes	☐ No
Does the student have signs or symptoms of active tuberculosis disease?	☐ Yes	☐ No

If **No** to all of the above, no testing is needed. . If **Yes** to any question, proceed with additional evaluation to exclude active or latent tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

1. Tuberculin Skin Test (TST) – *should be recorded as millimeters of induration, transverse diameter**

Date given: ___/___/___ (M D Y) Site: L R forearm Date read: ___/___/___ (M D Y) Result: ____mm induration

Date given: ___/___/___ (M D Y) Site: L R forearm Date read: ___/___/___ (M D Y) Result: ____mm induration

2. Interferon Gamma Release Assay (IGRA)

Date obtained: ___/___/___ (M D Y) Method: _____ Result: Negative___ Positive___ Intermediate___

Date obtained: ___/___/___ (M D Y) Method: _____ Result: Negative___ Positive___ Intermediate___

3. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ___/___/___ (M D Y) Result: normal____ abnormal_____ (please specify)

Signature of clinician completing this form_____ Date: ____/____/____ (M D Y)

***Interpretation guidelines**

>5mm is positive:

- **Recent close contacts of an individual with infectious TB**
- **Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease**
- **Organ transplant recipients**
- **Immunosuppressed persons: taking >15 mg/d of prednisone for >1 month, taking a TNF-a antagonist**
- **Persons with HIV/AIDS**

>10mm is positive:

- **Persons born in a high prevalence country or who resided in one for a significant amount of time**
- **History of illicit drug use**
- **Mycobacteriology laboratory personnel**
- **History of resident, worker or volunteer in high-risk congregate setting**
- **Medical condition associated with increased risk of progressing to TB disease**

>15 mm is positive:

- **Persons with no known risk factors for TB disease**