STUDENT SERVICES & ENROLLMENT MANAGEMENT
Admissions & Recruitment • Office of Student Financial Aid
Office of the Registrar • Student Life

Dear Future Meharrian:

Congratulations and Welcome to Meharry Medical College!

The Office of Admissions and Recruitment at Meharry is dedicated to assisting you with many areas of student life, which are vital to your success. We are here to help ensure your smooth transition into professional school and to provide support that will contribute to your academic and personal growth. The information presented below is very important and requires your immediate attention and response:

IMMUNIZATIONS

Prior to registration, all students entering Meharry Medical College must provide proof of prior immunization for measles, mumps, rubella, varicella (chicken pox), tetanus, diphtheria, pertussis, polio and Hepatitis B. A hard copy of the actual lab results of the quantitative serologic titers must also be submitted. Documentation of the results of tuberculosis screening within the last 12 months (PPD) is also required. Student Health Services will review all documentation submitted to determine adequacy.

Required Immunizations and Quantitative Serologic Titers:

- **Hepatitis B vaccinations**: documented series of 3 vaccines **and** Hepatitis B surface antibody quantitative serologic titer
- **MMR** (measles, mumps, rubella): documented series of two doses **and** quantitative serologic titers
- **Varicella**: documented series of two doses **and** quantitative serologic titer **or** documented dated of disease **and** quantitative serologic titer.
- **Tetanus/Diphtheria/Pertussis**: documentation of **TdAP** vaccine within the last 10 years
- **Polio**: documentation of last immunization
- **Tuberculosis Screening:** within the last 12 months: PPD result **or** documentation of previous positive PPD, subsequent treatment and most recent chest x-ray report

PHYSICAL EXAMINATION

Prior to registration, all students entering Meharry Medical College are required to have the Health Surveillance/Physical Examination forms completed by a health care provider. The physical exam should be performed within the last 12 months. If the health care provider has questions, please ask the health care provider to call Student Health Services at (615) 327-5757 for assistance.

If any additional information is needed, please contact the Office of Admissions & Recruitment at (615) 327-6223.

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NASHVILLE, TENNESSEE 37208-3599
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Student Health Services
HEALTH SURVEILLANCE / PHYSICAL EXAMINATION

1. STUDENT'S INFORMATION

Name: ______________________ SSN: ________________ Date: ________________

Date of Birth: __________ Age: ____________ Sex: ________ Home Phone: __________

School: ________________________________ Cell Phone Number: ____________

2. HEALTH HISTORY (STUDENT TO COMPLETE THIS SECTION)

YES	NO		YES	NO		YES	NO	
		Any illness or injury in the last 5 years?			High blood pressure			Loss of, or altered consciousness
		Head/Brain injuries, disorders or illnesses			Muscular disease			Fainting dizziness
		Seizures/epilepsy Medication__________ __________________			Shortness of breath			Sleep disorders, pauses in breathing while asleep, daytime sleeping, loud snoring
		Eye disorders or impaired vision (except corrective lenses)			Lung disease, emphysema, asthma, chronic bronchitis			Stroke or paralysis
		Ear disorders, loss of hearing or balance			Kidney disease, dialysis			Missing or impaired hand, arm, foot, legs, finger, toe
		Heart disease or heart attach; other cardiovascular condition Medication__________ __________________			Liver disease			Spinal injury or disease
					Digestive problems			Chronic low back pain
		Heart surgery (valve replacement/bypass, angioplasty, pacemaker)			Regular, frequent alcohol use			Narcotic or habit forming drug use
		Nervous or psychiatric disorders, e.g., severe depression Medication__________ __________________			Diabetes or elevated blood sugar controlled by: Diet Pills Insulin Medication__________ __________________			

For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

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_______________________________ _______________________________

Student's Signature Date

Pages 2, 3 and 4 to be completed by the Health Care Provider   **Name:** ______________________

3. VISION

Numerical readings must be provided.

ACUITY	UNCORRECTED	CORRECTED	HORIZONTAL FIELD OF VISION
Right Eye	20/	20/	Right Eye:
Left Eye	20/	20/	Left Eye:
Both Eyes			

Color Vision   Normal   Abnormal

Applicant meets visual acuity requirement only when wearing: Corrective Lenses

4. HEARING

A) Whisper Test   Right Ear: /Feet   Left Ear: /Feet

B) Audiometer Test   See attached reading

5. BLOOD PRESSURE/PULSE RATE

Blood Pressure: ______________________

Systolic: ______________________

Diastolic: ______________________

Pulse Rate: Regular   Irregular

Record Pulse Rate: ______________________

6. LABORATORY AND OTHER TEST FINDINGS

URINE SPECIMEN	SP.GR.	PROTEIN	BLOOD	SUGAR

7. PHYSICAL EXAMINATION

Height: ______________ (in.) Weight: ______________ (lbs.) BMI: ______________

BODY SYSTEM	CHECK FOR:	YES	NO
1. General Appearance	Marked overweight, tremor, signs of alcoholism, problem drinking or drug abuse		
2. Eyes	Pupils unequal, no reaction to light, impaired accommodation, impaired ocular motility, ocular muscle weakness, abnormal extraocular movements, nystagmus, exopthalmus. Ask about retinopathy, cataracts, aphakia, glaucoma, macular degeneration		
3. Ears	Scarring of tympanic membrane, occlusion of external canal, perforated eardrums		
4. Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing		
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker implantable defibrillator		

Pages 2, 3 and 4 to be completed by the Health Care Provider **Name:** ______________________

BODY SYSTEM	CHECK FOR:	YES	NO
6. Lungs and chest, not including breast examination	Abdominal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rales, impaired respiratory function, cyanosis. Abnormal findings on physical exam may require further testing such as pulmonary tests and/or x-ray of chest.		
7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness		
8. Vascular System	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins		
9. Genito-urinary	Hernias		
10. Extremities	Loss of impairment of leg, foot, toe, arm, hand, finger, perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp and prehension in upper limb to maintain grip. Insufficient mobility and strength in lower limbs.		
11. Spine, other musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness.		
12. Neurological	Impaired equilibrium, coordination of speech pattern; asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal Patellar and Babinki's reflexes, ataxia		

COMMENTS:

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Health Care Provider's Signature Date

Pages 2, 3 and 4 to be completed by the Health Care Provider **Name:** ____________________

8. IMMUNIZATION RECORD	
MMR VACCINE	Date of Immunization #1 #2
MUMPS	Date and Result of Titer
RUBEOLA	Date and Result of Titer
RUBELLA	Date and Result of Titer
VARICELLA	Date of Immunization
VARICELLA	Date and Result of Titer
HEPATITIS B	Dates of Immunization #1 ________ #2 ________ #3 ________ Date and Result of Titer
Td or TdAP	Date
POLIO	Date of Last Immunization
PPD	Date and Result
Chest X-Ray (If Required)	Date and Result

1. Does the student have any medical or psychiatric diagnoses that may interfere with their matriculation in professional/graduate school?

   No Yes If yes, please explain: ____________________

2. Are you the student's primary care provider?	No	Yes

Health Care Provider's Signature & Date: ____________________

Printed Name: ____________________

Address: ____________________

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