Physical Examination Form

Please print or type all information

Please check one of the following before proceeding:

Program: ❑ PN ❑ Day ❑ Evening
Program: ❑ CNA ❑ Day ❑ Evening

Name: _____
Last First MI

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Date of Birth: _____

Parent/Guardian: _____ Address: _____
(High School students only) Last First MI Street City State Zip Telephone

Examining Physician: _____ Address: _____
Last First MI Street City State Zip Telephone

Family History: (list familial diseases: diabetes tuberculosis mental illness other)

_____

HEALTH HISTORY (Please check (x) those which apply)

Usual Childhood Diseases: ❑ Measles ❑ Mumps ❑ Chicken Pox ❑ German Measles (Rubella)

Orthopedic Problems: ❑ Arthritis (type) _____

Allergic Problems (reactions): ❑ Asthma ❑ Hay Fever ❑ Hives ❑ Eczema ❑ Other _____

Cardiac (Heart) or Vascular problems: ❑ Congenital ❑ Rheumatic Fever ❑ Hypertension (blood pressure)

Operations (include dates): _____

Injuries-severe (include dates): _____

Days of illness last year: _____ Known drug allergies: _____

Other medical problem(s): _____

Other:

❑ Diabetes ❑ Convulsive Disorder ❑ TB (or known exposure)

❑ Medication(s) _____

_____

_____

_____

❑ Pulmonary: (lungs) Type: _____

❑ Hepatitis: Type _____

Revised: February 2012

MJ/sk

- over -

I **TUBERCULIN TESTING:** as close to enrollment as possible. Health Occupations students and staff **must have TB skin test**. **All first time Health Career staff/students MUST take the Two-Step PPD.**

Test I Date: _____ Results _____

Test II Date: _____ Results _____
If test is positive, proof of a negative Chest X-Ray and yearly medical history.

Test Date: _____ Results _____

II **RUBEOLA** (Measles) **IMMUNITY DOCUMENTATION**
Need two (2) measles immunizations

Students born after 1957:
Immunization Dates: #1 _____
#2 _____

Students born before 1957 need:

Titre Results: _____ Date: _____
or
MMR: _____ Date: _____

III **RUBELLA** (German Measles) **IMMUNITY DOCUMENTATION**

Immunization Date: _____
-or-
Titre Results: _____

IV **MUMPS IMMUNITY DOCUMENTATION**

Students born after 1957:
Immunization Date: _____

Students born before 1957:
Titre Results: _____

V **TETANUS IMMUNITY DOCUMENTATION**

If TD Booster within 5 years, check here ❑ Date: _____

T dap immunization date (if over 5 years): ❑ Date: _____

VI **VARICELLA** (Chicken Pox)**IMMUNITY DOCUMENTATION**

Disease Date: _____

Titre Results: _____ Date: _____

VII **HEPATITIS** (Optional)
VACCINATION DOCUMENTATION
Immunization Dates:
#1 _____
#2 _____
#3 _____

Titre Results: _____

2 vaccines, one month apart, if negative Titre

Immunization Date #1: _____

Immunization Date #2: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____
Eyes: (Vision): Glasses _____ Y _____ N C/G RT _____ LT _____ S/G RT _____ LT _____
Hearing: RT _____ LT _____ Nose: _____
Throat & Mouth: Teeth: _____ Thyroid: _____ Tonsils: _____
Lymph Glands: Cervical _____ Axillary _____ Inguinal _____
Chest: Respirations _____ Lungs _____ Heart-Rhythm _____ Sounds _____ Murmur _____
Abdomen: Appearance _____ Scars _____ Hernia _____
Genitalia: Testes: _____ Pelvic (if indicated) _____
Neuromuscular: Back: (include scoliosis screen) _____
Arms/Hands _____ Legs/Feet _____ CNS (reflexes) _____

I have examined the above and found him/her to be in satisfactory physical condition to care for patients in clinical setting:

Yes _____ ***No*** _____ ***Any restrictions?*** _____

PHYSICIAN'S SIGNATURE: _____ ***Date:*** _____

LICENSE NUMBER: _____

HEPATITIS B VACCINE DECLINATION

I understand that due to my exposure to blood and other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been informed about the hepatitis B vaccination. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease.

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____