AIMS EDUCATION PHYSICAL EXAMINATION FORM

PERSONAL INFORMATION					
Last Name		First Name		Middle Initial	
DOB		Street Address		City	
State & Zip Code		Cell Phone		Primary Email	
Emergency Contact		Family Physician			

PHYSICAL EXAMINATION - MUST BE COMPLETED BY YOUR HEALTHCARE PROVIDER					
Height		Weight			
Blood Pressure		Hearing			
Vision		Extremities		Back and Spine	

As a student in an allied health training program, he or she may be required to do the following:

1. Provide support to patients (walking, standing, getting out of bed, etc.) Have the ability to lift up to 50 pounds.
2. Communicate with patients, family members, and other healthcare professionals.
3. Provide written documentation.
4. Observe and record visual changes in patients and or their environment.
5. Operate computers and/or medical equipment that require manual dexterity.
6. Participate in invasive procedures.

Is he/she physically and emotionally capable of participating in all of the classroom and clinical activities required for an allied health training program? _____Yes/_____No

Additional Comments (if necessary):_____

Medical History – If answer to any of the following is 'yes', please provide details in the box below		
1. Injuries / Medical & Surgical history	Yes/No	
2. Allergies to medication / latex allergy / other	Yes/No	
3. Medications taken on regular basis	Yes/No	
4. Does the patient's medical history include any communicable diseases or mental disorder?	Yes/No	

MMR (Measles, Mumps, Rubella) – Two (2) doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps, and (1) dose of Rubella; or serologic proof of immunity for Measles, Mumps, and Rubella.

Option 1	**Vaccine or Test**	**Date**	**Result**
MMR - 2 doses of MMR vaccine	MMR dose # 1	___/___/___	
	MMR dose # 2	___/___/___	
Option 2			
Measles - 2 doses of vaccine **or** serologic immunity	Measles vaccine dose #1	___/___/___	
	Measles vaccine dose #2	___/___/___	
	Serologic Immunity (IgG, antibodies, titer)	___/___/___	Immune / Non-Immune
Mumps - 2 doses of vaccine **or** serologic immunity	Mumps vaccine dose #1	___/___/___	
	Mumps vaccine dose #2	___/___/___	
	Serologic Immunity (IgG, antibodies, titer)	___/___/___	Immune / Non-Immune
Rubella - 1 dose of vaccine **or** serologic immunity	Rubella vaccine	___/___/___	
	Serologic Immunity (IgG, antibodies, titer)	___/___/___	Immune / Non-Immune

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Hepatitis B Vaccination – Three (3) doses of vaccine or serologic immunity.
(Required for enrollment. Students must have at least first two doses prior to internship)

		Date	**Result**
Hepatitis - 3 doses of vaccine **or** serologic immunity	Hepatitis B vaccine dose #1	___/___/___	
	Hepatitis B vaccine dose #2	___/___/___	
	Hepatitis B vaccine dose #3	___/___/___	
	Serologic Immunity	___/___/___	Immune/Non-Immune

Varicella (Chicken Pox) – 2 doses of vaccine or history of chicken pox or serologic immunity.

		Date	**Result**
Varicella - 2 doses of vaccine **or** chicken pox **or** serologic immunity	Varicella vaccine #1	___/___/___	
	Varicella vaccine #2	___/___/___	
	Chicken Pox	___/___/___	
	Serologic Immunity (IgG, antibodies, titer).	___/___/___	Immune/Non-Immune

Tuberculosis Screening – Results of last (2) PPDs or Quantiferon or T – spot are required regardless of prior BCG status. If you have a history of a positive TST (PPD) >/10mm or IGRA please attach related documentation regarding any evaluation (e.g. Chest X-ray) and / or treatment. ***(Must be updated prior to internship)***

		Date Placed	**Date Read**	**Reading**	**Interpretation**
Skin or Blood Test History **(mandatory within last year)** - 2 PPDs **or** Quantiferon / T-spot	PPD #1 Arm: L / R	__/__/___	___/___/___	__mm	Positive / Negative
	PPD #2 Arm: L / R	__/__/__	___/___/___	__mm	Positive / Negative
			Date	**Result**	
	Quantiferon or T-spot, TB test (Interferon gamma releasing assay).		___/___/___	Negative / Positive	
	Chest X Ray **(mandatory within last year, if positive PPD).**		___/___/___	Negative / Positive	

Tetanus – diphtheria – pertussis – ***(Not required for enrollment but may be required prior to internship)*** One (1) dose of adult Tdap. If last Tdap is more than 10 years old, provide date of last Td and Tdap

		Date	
	Tdap vaccine (Adacel, Boostrix, etc.)	___/___/___	
	Td vaccine (if more than 10 years since last Tdap).	___/___/___	

Influenza Vaccine ***(Not required at the time of enrollment but may be required prior to internship)***

	Flu vaccine	___/___/___	If denying vaccination, attach supporting documentation.
	Flu vaccine	___/___/___	

Healthcare Provider Name and Address		Phone	
		Email	
		Fax	
Authorized Signature		Date	