



Physical Examination Report

Part I Personal Information (to be completed by a physician)

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____

Family Physician: _____ Phone: _____

Part II Physical Examination (to be completed by a physician)

Height _____ Weight _____ BP _____ Hearing _____ Vision _____ Extremities: _____ Back & Spine: _____

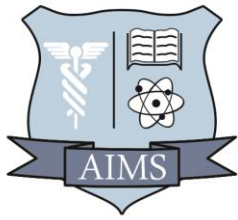
Does the patient's medical history include any communicable diseases? ____ Yes ____ No (If yes, please specify and provide details)

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.

Is he or 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):



Part III Medical History (to be completed by a physician - dates need not be exact)

A. Check disease or illness that you have had:

Table with 8 columns and 3 rows listing diseases: Measles, Mononucleosis, Hay Fever, Asthma, Pneumonia, Hepatitis, Mumps, Rheumatic Fever, Scarlet Fever, Chicken Pox, Kidney Disease, Cardiac Problems.

Other serious disease _____

Allergies to Medicines/Latex allergy screen/other: _____

Injuries/ Medical & Surgical History: _____

List medication(s) taken on regular basis: _____

B. Mandatory Tests and Immunizations (please attach supporting documentation)

NOTE: If Titer results are "NON IMMUNE", you MUST get the vaccine (unless advised otherwise by a physician – attach waiver documentation).

1. Tuberculosis (TB) test (please choose Option A or Option B):

Option A: Two-step PPD skin test (circle results)

(1)Date Placed _____ Date Read _____ Result: NEG / POS (2) Date Placed _____ Date Read _____ Result: NEG / POS

If Positive, Chest X-ray Result: _____

Option B: QuantiFERON or T-SPOT TB test (circle result) Date _____ Result: NEG / POS

2. Hepatitis B: Vaccine Date 1 _____ Date 2 _____ Date 3 _____ OR Titer Date _____ Result: IMMUNE/NON IMMUNE

3. Measles: Vaccine Date 1 _____ Date 2 _____ OR Titer Date _____ Result: IMMUNE/NON IMMUNE

4. Varicella: Vaccine Date 1 _____ Date 2 _____ OR Titer Date _____ Result: IMMUNE/NON IMMUNE

If you have not had titer but had Chicken Pox, indicate the date of case: _____

5. Rubella: Date 1 _____ Date 2 _____ OR Titer Date _____ Result: IMMUNE/NON IMMUNE

6. Tetanus / Td (may be required prior to internship): Date _____

7. Seasonal Flu vaccination (may be required prior to internship): Date _____

*As of 9/26/13, it is now a requirement of the CDC and JCAHO to have this vaccination if you are a healthcare worker directly involved with patients. If, for some reason(s), you do not get this vaccination, you will need supplemental documentation and also your clinical internship site may ask you to sign a waiver and/or wear a protective mask while on duty.

8. Urinalysis for Drug Screening (if required- attach results): Date _____

Physician's Name: _____ Signature: _____

Address: _____

Signature: _____ Date: _____