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STUDENT PHYSICAL EXAMINATION

(To be signed by a physician, physician assistant or nurse practitioner)

Physical examination and TB tests must be done within 90 days before starting clinical training. Must use this form. Completion of this form is REQUIRED prior to the start of clinical training (NO EXCEPTIONS!)

Name: _____ Telephone: (_____)_____

Address: _____ City: _____ Zip: _____

DOB: _____ Place of Birth:_____

Date of Examination: _____ Vital Signs: T: _____ PR _____ RR _____ B/P _____

Sufficient Visual and Hearing acuity: YES ( ) NO ( )

Checklist	**Normal**	**/ Abnormal**	**Comments**
Skin	_____	_____	_____
HEENT	_____	_____	_____
Neck/Nodes	_____	_____	_____
Lungs	_____	_____	_____
Cardiac	_____	_____	_____
Abdomen	_____	_____	_____
MSK	_____	_____	_____
Nervous system	_____	_____	_____

TB TEST (within 90 days before clinical training):

A. Skin Test/Blood test: Date Tested: _____ Result: _____

B. If POSITIVE SKIN TEST (physician must enter the following information):

Date of CXR: _____ Result: _____

Attach copy of radiology report with this form.

C. A CXR for history of a positive (+) reaction from skin test or blood test (within one year before clinical training)

Date of CXR: _____ Result: _____

Has this person been prescribed prescriptions to treat TB? Yes ( ) No ( )

If YES, please list prescribed medications:

_____

HEPATITIS B VACCINE: Dates given: _____

A. Hep. B serum antibody titer (if no proof of immunization) Date done: _____

B. Hepatitis B vaccine: _____ Yes _____ No

C. If NO, Hepatitis B vaccine: Date of #1: _____Date of #2: _____ Date of #3 _____

INFLUENZA VACCINE (between October to April only): Date given: _____

HEALTHCARE PROVIDER ATTESTATION:

A. _____ I have examined the above named student and find that he/she is FREE of any condition that would be hazardous to her/him, fellow students, patients, school and/or hospital staff. This student have a high degree of physical (including but not limited to lifting up to 50 lbs. unassisted) and transfer with adult patients and mental fitness to work safely with patients

B. _____ I have examined the above named student and find that he/she has a condition that may hazardous to her/him, students, patients, school and/or hospital staff.

Please describe conditions: _____

Date: _____

Physician's PRINTED name: _____

Physician's SIGNATURE: _____

Office/Clinic address: _____

_____