PHYSICAL EXAMINATION (please print in black ink) **To be completed and signed by Physician**

Date of Examination MUST Be Within 1 Year of the First Day of Classes.

Last Name	First Name	Middle Name	Date of Birth (month/day/year)	Examination Date

HEIGHT __________________ **WEIGHT** _______________ **Vital Signs: TPR** _____/_____/_____ **BP** _____/_____

(Specialist exams not required)

Vision: Corrected Right 20/_____
Left 20/______
Uncorrected Right 20/_____
Left 20/______
Color Vision

Hearing: (gross) Right ________
Left ________
15 ft. Right ________
Left _________

(Required tests)

Urinalysis: Sugar _____________ Albumin ___________

Micro ________________________________

Hgb or Hct (if indicated) ____________________________

Date ______________ Results ________________________

Recommendations ____________________________________

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Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Mouth, Throat			
2. Eyes (Include glasses: reading/continuous)			
3. Cardiovascular (Heart/Circulation evaluation)			
4. Respiratory (Airway/Chest and Lungs)			
5. PPD (If positive, chest x-ray _______Date)			Date _____/______ Results (If positive, attach report)
6. Abdominal			
7. Endocrine (Include thyroid problems/diabetes, etc.)			
8. Musculoskeletal/Neurological:			
a. Sensory (other than previously noted)			
b. Motor (condition of spine/extremities?)			
11. Skin (Include latex sensitivity)			
12. Rubella/Hepatitis Screen (If no immuniz. proof)			

A. Is there loss or seriously impaired function of any paired organs? Yes _____ No ______
Explain ____

B. Is student under treatment for any medical, psychological, or emotional condition? Yes _____ No ______
Explain ____

C. Recommendation for physical activity. Unlimited _________ Limited _________
Explain ____

D. Is student physically, psychologically, and emotionally healthy? Yes _____ No ______
Explain ____

Based on my assessment of this student's physical and emotional health on __________________, he/she appears able to participate in all activities. Yes _____ No ______ If no, please explain ____

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____ ____________________

Signature of Physician Date

____ ____________________

Print Name of Physician State License Number

IMMUNIZATION RECORDS (please print in black ink)	**To be completed and signed by Physician**

This form must be completed and signed by a licensed physician, physician's assistant, or nurse practitioner.

Last Name **First Name** **Middle Name**	**Date of Birth (month/day/year)**	**Examination Date**

Students are required to submit proof of current immunizations (AN OFFICIAL RECORD MUST BE ATTACHED) for the following. If immunizations are received at this visit, please indicate below.

SECTION A - IMMUNIZATIONS				
	Month/Day/Year	**Month/Day/Year**	**Month/Day/Year**	**Month/Day/Year**
DTP or Td				
Td Booster				
Polio				
MMR				
MR				
Hepatitis B series – Must have first in series before start of program **Titer date & Results (Attach Report)				
	Applied	**Read**	**Result**	**MD/Nurse Signature**
Tuberculin (PPD) Test (Tine Test Not Acceptable)				
Chest x-ray if positive PPD Date				
Results				
Treatment, if applicable Date				

SECTION B – OPTIONAL IMMUNIZATIONS			
	Month/Day/Year	**Month/Day/Year**	**Month/Day/Year**
Haemophilus influenza type B			
Pneumococcal			
Meningococcal			
Hepatitis A series			
Typhoid (specify type)			
Varicella (chicken pox) series or documentation of immunity **Titer date and results			

IN YOUR PROFESSIONAL OPINION, PLEASE LIST ANY MEDICAL CONDITION THAT WOULD PREVENT THIS PERSON FROM PERFORMING THE DUTIES OF A STUDENT IN THIS PROGRAM.

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Signature, Address, and Telephone Number are REQUIRED:

____ ______________

Signature of Physician/Physician Assistant/Nurse Practitioner Date

____ ______________

Print Name of Physician/Physician Assistant/Nurse Practitioner State License Number

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Office Address and Telephone Number (*Clinic stamp is acceptable*)