



**TRINITY COLLEGE  
OF NURSING & HEALTH SCIENCES**  
Medical Examination

Last Name	First Name	Middle Name	Social Security Number
Educational Program	Start Date (MM/YY)	Date of Birth (MM/DD/YY)	

I, \_\_\_\_\_ (Student Signature) authorize release of medical information to Trinity College of Nursing and Health Sciences.

**Please note that the remainder of this form must be filled out and signed by a physician or licensed practitioner.**

Gender: _____	Height: _____	Weight: _____		
Temperature: _____	Pulse: _____	Respiration: _____	Blood Pressure: _____	
Eyes/Vision: _____	O.S. _____	O.D. _____	Glasses/Contacts: YES NO	
Corrected Vision: _____	O.S. _____	O.D. _____		
Ears: _____	Normal _____	Impaired _____	Hearing Aid YES NO	

Throat, Tonsils, Thyroid: \_\_\_\_\_

Skin: \_\_\_\_\_

Skeletal: \_\_\_\_\_

Heart: \_\_\_\_\_ Lungs: \_\_\_\_\_

Chest: \_\_\_\_\_ Lymph Nodes: \_\_\_\_\_

Abdomen: \_\_\_\_\_ Hernia: \_\_\_\_\_

Rectal: \_\_\_\_\_ Prostate/Vaginal \_\_\_\_\_

Nervous System: Reflexes: \_\_\_\_\_ Balance: \_\_\_\_\_ Coordination: \_\_\_\_\_ Gait: \_\_\_\_\_

Family History: \_\_\_\_\_

History of Mental Illness: \_\_\_\_\_

Menstrual History: \_\_\_\_\_

Allergies: \_\_\_\_\_

Drug Reaction or Sensitivity: \_\_\_\_\_

Summary: \_\_\_\_\_

List any health-related problems/surgeries that would prohibit the learner from completing a health education program?

\_\_\_\_\_

\_\_\_\_\_

The following immunizations are required prior to enrolling at Trinity College of Nursing and Health Sciences.

<b>Immunization</b>	<b>First</b>	<b>Second</b>	<b>Third</b>	<b>Booster</b>
Diphtheria, Pertussis, Tetanus (DPT) (DT)	_____	_____	_____	_____
Tetanus Diphtheria Booster or (TD) {TD Booster is required every 10 years}			_____	_____
Varicella (Chickenpox) Disease	Date: _____			
Immunization	#1	_____		
Immunization	#2	_____		

**Vaccination required for health care providers unless documented immunity.**

Measles, Mumps, Rubella (MMR) \_\_\_\_\_ Rubella Titer \_\_\_\_\_ **OR**  
**Doctor documented date of disease:** Rubeola \_\_\_\_\_ Rubella \_\_\_\_\_ Mumps \_\_\_\_\_

**Testing required for all Illinois health care providers (within three months prior to entrance of program)**

Tuberculin (Mantoux – 2 Step) 1 week apart

Step One Date	_____	Result	_____
Date Two Date	_____	Result	_____

Hepatitis B Vaccination (Must have at least one before entry into School Program)

Number	Date of Vaccination	Vaccination Lot Number	Dosage	Site of Vaccination	Vaccination Given by/Signature
1	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____

***Hepatitis B titer required. Hepatitis B titer should be drawn at least 1 month following completion of Hepatitis B series.***

Hepatitis B Titer Date: \_\_\_\_\_ Titer Results: \_\_\_\_\_

If starting series, please submit this form after the first injection and provide written proof of second and third injections and titer after each completion.

I have given \_\_\_\_\_ a careful physical examination and found the individual to be in \_\_\_\_\_ health.

\_\_\_\_\_  
Signature of Physician or Licensed Practitioner

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Office Telephone Number

\_\_\_\_\_  
City/State/Zip Code

**NOTE: The student should return this completed form directly to:**  
*Trinity College  
of Nursing & Health Sciences  
Attention: Student Services Health Records  
2122 25<sup>th</sup> AVE  
Rock Island, IL 61201-5317*