



Physical Examination Form - Nursing & Respiratory Care Students

To the best of my knowledge, I do not have a physical or mental condition that would prevent me from performing the essential requirements of the applicable program. I hereby authorize the release of my medical information to clinical affiliates after my admission and prior to being assigned to a clinical rotation. I understand that I may be dismissed from the program if I knowingly submit false information.

Student Signature: _____ Date: _____

Printed Name (First MI Last): _____ DOB (MM/DD/YYYY): _____

INSTRUCTIONS TO STUDENT:

This form must be filled out by applicant and a licensed primary care provider (physician, physician's assistant, nurse practitioner). Physical examinations must be completed no sooner than one year prior to entering the program. The QuantiFERON Gold test cannot be performed earlier than six months prior to the start of classes.

PLEASE NOTE: THE REMAINDER OF THIS FORM MUST BE FILLED OUT AND SIGNED BY A LICENSED PRACTITIONER (MD, PA, OR NP).

Gender: _____ Height: _____ Weight: _____ T: _____ P: _____ R: _____ BP: _____ / _____

Vision: OD _____ OS _____ Corrected? Yes No

	NORMAL	ABNORMAL	NOTES
Ears			
Throat			
Tonsils			
Thyroid			
Skin			
Skeletal			
Heart			
Chest			
Abdomen			
Lungs			
Lymph Nodes			
Hernia			
Reflexes			
Balance			
Coordination			
Gait			

Additional Notes/ Summary: _____

Family History: _____

History of Mental Illness: _____

Allergies: _____

Drug Reaction or Sensitivity: _____

List any health-related problem/surgeries that could prohibit the student from completing a health education program: _____



REQUIRED TUBERCULOSIS SCREENING

Students participating in clinical rotations at both Genesis Health System and UnityPoint Health – Trinity are required to complete a QuantiFERON Gold blood test to verify the student is free from an active TB infection. Note: Students with a positive TB result will have alternative steps for completing this requirement. Please contact Student Services for additional information. **The QuantiFERON Gold test cannot be performed earlier than six months prior to the start of classes.**

QuantiFERON Gold Date _____ Result _____

IMMUNIZATIONS

Hepatitis B immunity must be documented by record of three hepatitis B immunizations **AND** a positive hepatitis antibody titer report. Students who do not have documented immunity to hepatitis B must have received the first two of three hepatitis immunizations in the first series in order to matriculate. Please submit this form after the first two injections and provide written proof of the additional injection and titer after each completion. **Please include proof of titer result.**

Number	Date of Vaccination	Vaccination Lot #	Dosage	Site of Vaccination	Given by (Initial)
1					
2					
3					

Hepatitis B Titer Date: _____ Titer Results: _____

The following can be completed by your provider, or you may submit separate documentation showing your immunizations (i.e. a county health department proof of immunizations). Each of the four diseases require either proof of immunizations, a history of the disease, **OR** a titer to verify immunity. Fill in the date in the appropriate space.

For a titer, please include proof of the result.

- Varicella (Chickenpox)**
 Disease (month/year) _____ Immunization #1 _____ Titer _____
 Immunization #2 _____ Result _____
- Measles**
 Disease (month/year) _____ Immunization #1 _____ Titer _____
 Immunization #2 _____ Result _____
- Mumps**
 Disease (month/year) _____ Immunization #1 _____ Titer _____
 Immunization #2 _____ Result _____
- Rubella**
 Disease (month/year) _____ Immunization #1 _____ Titer _____
 Immunization #2 _____ Result _____

Tetanus protection is demonstrated by documentation of a tetanus immunization. Tetanus must be updated with any breach in skin integrity.

Date of most recent tetanus: _____

ENDORSEMENT

Health Care Provider must fill out in full to validate.

I have given _____ a careful physical examination on this date, _____ and I have found the student is able to participate in class and clinical experiences: without restrictions with restrictions I do NOT endorse this student to participate at this time.

Signature of licensed practitioner

Printed name

Printed credentials

Address, City, State, Zip

THE STUDENT SHOULD RETURN COMPLETED FORM TO STUDENT SERVICES AT THE ADDRESS BELOW.