Trinity College of Nursing & Health Sciences
UnityPoint Health

Physical Examination Form - Radiography & BSHS 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. At least one of the TB skin tests cannot be administered earlier than three 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: ______________________________

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REQUIRED TUBERCULOSIS SCREENING

A two-step TB test must be completed prior to entrance in program. One test may be up to one year old; one test must be completed within three months of entrance in program. Note: Students with a positive TB result will have alternative steps for completing this requirement. Please contact Student Services for additional information.

Step 1 Date ________________ Result ________________
Step 2 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: ________________

COVID-19 protection is demonstrated by documentation of full COVID immunization Immunization #1 ________________ Vaccine
Immunization #2 ________________ Manufacturer ________________

PHYSICIAN 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.