Trinity College of Nursing
& Health Sciences
UnityPoint Health

Physical Examination Form

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: _____

_____

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REQUIRED TUBERCULOSIS SCREENING

Students participating in clinical rotations 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 ninety days prior to the start of clinical rotations.

QuantiFERON Gold Date _____ Result _____

IMMUNIZATIONS

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 OR a titer to verify immunity. Fill in the date in the appropriate space. For a titer, please include proof of the result.

	Immunization #1	Immunization #2	Titer Date	Result
Varicella				
Measles				
Mumps				
Rubella				

Tetanus protection is demonstrated by documentation of a tetanus immunization within the past ten years. Tetanus must be updated with any breach of skin integrity. Date of most recent tetanus: _____

The **Hepatitis B** immunization series is not required, but strongly recommended. To meet the hepatitis B requirement, students must provide one of the following:

1) Documentation of a completed hep B series (either 2 doses of Heplisav-B or a 3 dose series)
2) A signed declination form.

Students who do not have documented immunity to hepatitis B and wish to become vaccinated must have received the first immunization in the series in order to matriculate. Please submit this form after the first injection and provide written proof of additional injections after each completion in order to enter and continue in clinical courses.

*Please contact the College if you do not wish to be vaccinated against Hep B and need a declination form.

Number	Date of hepatitis B vaccination	Vaccination lot #	Dosage	Site of vaccination	Given by (initial)
1					
2					
3					

COVID-19 immunizations are not required, but strongly recommended for all students. To meet the COVID-19 requirement, students must provide one of the following:

1) Documentation of a full COVID immunization series
2) A signed declination form.

*Please contact the College if you do not wish to be vaccinated against COVID-19 and need a declination form.

MEDICAL PROVIDER ENDORSEMENT: Health Care Provider must fill out in full to validate.

I have given _____ a careful physical examination in 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.