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

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 Immunization #1 _____ History of disease (month/year) _____
Immunization #2 _____ Varicella titer _____

Measles Immunization #1 _____ History of disease (month/year) _____
Immunization #2 _____ Measles titer _____

Mumps Immunization #1 _____ History of disease (month/year) _____
Immunization #2 _____ Mumps titer _____

Rubella Immunization #1 _____ History of disease (month/year) _____
Immunization #2 _____ Rubella titer _____

Tetanus - protection is demonstrated by documentation of a tetanus immunization within the past 10 years from a student's start at Trinity College of Nursing & Health Sciences. Tetanus must be updated with any breach in skin integrity. Date of most recent tetanus: _____

Protection against **COVID** is strongly recommended. If vaccinated, please provide dates.

Immunization #1 _____ Immunization #2 _____ Booster _____ Booster _____

Protection against **Hepatitis B** is strongly recommended. If vaccinated, please provide dates.

Immunization #1 _____ Immunization #2 _____ Immunization #3 _____

Hep B Titer _____ Titer Result _____

Protection against **Pertussis** is strongly recommended. If vaccinated, please provide most recent date of immunization. _____

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.