



Physical Examination Form - RAD Readmitted 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

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

If your immunizations were submitted during your original enrollment, they should still be on file. **Review the incomplete documents through your My Pulse account or contact our office to see if you are required to submit any additional immunizations.**

Influenza protection is demonstrated by documentation of a seasonal flu shot. Flu shots are required each year and may not be waived unless medically necessary to do so.

Date of most recent flu shot: _____

COVID-19 protection is demonstrated by documentation of full COVID immunization

Immunization #1 _____ 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.