

## **Physical Examination Form**

Student Name:	Sex: M F Birth date:							
Training Program:	onal Health Care Worker (CN	(A)						
TO BE COMPLETED BY PHYSICIAN OR NURSE PRACTITIONER								
1. Is the student able to perform clinical externship and employer	n the duties necessary for the training ment?	ng program checked above inc	eluding a					
2. Medications used: Prescription	on and over-the-counter (attachment	ts may be added)	-					
<u>Name</u>	<u>Indication</u>	<b>Frequency</b>						
Significant medical history, a      Examination Comments and	findings:	communicable diseases:	· ·					
	mmunicable nor disabling disease no mates or patients at this time. He/sh							
Examiner Name (please print):		Phone:	-					
Examiner Signature:		Date:						
<u> </u>	copy of this form to affiliating clinic e course instructor and the client ser	<u> </u>						
Student Signature:	Da	te·						

## **Physical Examination Form (Continued)**

Student Name:						
Required Tuberculosis Sci	eenir	ag (PPD)				
To Be Completed by Physi	cian (	or Nurse Practitio	<u>oner</u>			
Option 1:			Initials	Date and	Results	
Quantiferon- Gold						
Option 2: Please note: Step 1 and Step 2 must be 1-3 weeks apart.	Date Administered		Initials	Date and	Date and Result in Millimeters	
Step 1:						
Step 2:						
Chest x-ray (if positive PPD, otherwise, N/A)	Please attach results					
Immunization History  To Be Completed by Physi	cion d	or Nursa Practitic	nnor -			
Please attach lab results an						
Immunization		Date(s) Given		Titer Results	Initials	
Hepatitis B (3-part series or T	iter)					
Varicella (2-Vaccines or Tite	er)					

Please email the completed form to;

MMR( Measles/Mumps/Rubella)

Tdap ( every 10 years)

(2 Vaccines or Titer)

Influenza

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