

Physical Examination Form

Student Name:	Sex:	Sex: M F Birth date:		
Training Program:	Assistant Professi	onal Health Care Worker (CN	JA)	
TO BE COMPLETED BY PHYS	ICIAN OR NURSE PRACTITI	<u>ONER</u>		
1. Is the student able to perform to clinical externship and employement	ent?	g program checked above inc	cluding a	
Medications used: Prescription	and over-the-counter (attachment	s may be added)	_	
<u>Name</u>	<u>Indication</u>	Frequency		
3. Significant medical history, ac	cidents, surgeries, back problems,	communicable diseases:	_	
4. Examination Comments and fi	ndings:		_	
The above named has neither comhazard to himself, visitors, classmarequired for the training.				
Examiner Name (please print):		Phone:	_	
Examiner Signature:		Date:	_	
<u> </u>	copy of this form to affiliating clinicourse instructor and the client ser	•		
Student Signature	Do	to		



Physical Examination Form (Continued)

Student Name:					
Required Tuberculosis Scr	reening (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 Result in Millimeters		
Step 1:					
Step 2:					
Chest x-ray (if positive PPD, otherwise, N/A)	Please attach results				
mmunization History To Be Completed by Physi Please attach lab results ar					
Immunization	Date(s) Given		Titer Results	Initials	
Hepatitis B (3-part series or T	iter)				
Varicella (2-Vaccines or Tite	er)				
Tdap (every 10 years)					
MMR(Measles/Mumps/Rubo (2 Vaccines or Titer)	ella)				

Please email the completed form to:

Influenza