# HEALTH EXAMINATION BY PHYSICIAN

Name of applicant ____________________________________________________________________

Date of birth ________________ Weight _________ Height _________

**PLEASE CHECK THE APPROPRIATE PROGRAM.**

☐**ADN** ☐**LPN** ☐**EARN Nursing Pathway**

☐**MLT** ☐**MT** ☐**PTA** ☐**RADT** ☐**RTT**

## I. Do you have a history of diseases of the following?

Please answer **YES** or **NO**.

If you answer **YES** – please explain:

| | Yes | No | Explanation |
|---|---|---|---|
| Skin | | | |
| Eyes/Vision | | | |
| Ears/Hearing | | | |
| Cardiac | | | |
| Lungs/Respiratory Illness | | | |
| Musculoskeletal | | | |
| Diabetes | | | |
| Neurological/Seizures | | | |
| Abdominal (Hernias) | | | |
| Vascular (Varicose Veins) | | | |
| Allergies | | | |

List any medication or drugs taken frequently.

______________________________________________________________________________

Physical activity limitations?

Yes _______ No _______ Explain: ____________________________________________________

## II. Please provide dates of either immunization or proof of immunity of the following:

| | Proof of Immunity (Titer) or Date of Immunization/s |
|---|---|
| Measles (rubeola)<br>• 2 live vaccinations after 1st birthday | |
| Mumps<br>• 2 live vaccinations after 1st birthday | |
| Rubella (German Measles)<br>• 1 live vaccination after 1st birthday | |
| T-DAP | **Date of immunization:** |
| Varicella (Chicken Pox) | |

* *If you were given the immunization prior to 1975 you may wish to protect yourself by having the immunization repeated.*

** Some clinical affiliates may ask for a titer.*

## III. Required Laboratory Tests

IGRA (TB Gold) DATE ________ RESULTS _________

- (Chest X-Ray PA & Lateral) if IGRA is positive DATE ________ RESULTS _________

10 panel expanded opiates drug screen DATE ________

*RESULTS must be submitted to program director

**DO YOU CONSIDER THE APPLICANT PHYSICALLY AND EMOTIONALLY ABLE TO UNDERTAKE A PROGRAM IN THE HEALTH SCIENCES?**

**YES ______** **NO ______**

REMARKS:

Physician's Name ______________________________________________

Office Address ______________________________________________

Telephone ______________________________________________

______________________________ ______________________

*Physician's Signature* *Date of Examination*

*****Cost of the physical examination, laboratory tests and immunizations assumed by applicant.**

**PLEASE RETURN THIS FORM TO THE APPROPRIATE PROGRAM DIRECTOR AT:**

**Washington State Community College**
**710 Colegate Drive**
**Marietta, Ohio 45750**