ANNUAL UPDATE OF HEALTH EXAMINATION BY PHYSICIAN

Name of applicant _____

Date of birth _____ Weight _____ Height _____

PLEASE CHECK THE APPROPRIATE PROGRAM.

☐**ADN** ☐**MLT** ☐**PTA** ☐**RTT**
☐**LPN** ☐**MT** ☐**RADT**

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: _____

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

Revised: May 2018