

History and Physical Exam

For Respiratory Therapy Technology Program

Name of Applicant _____

Date of Birth _____ Weight _____ Height _____

Physical Exam: To be completed by a physician or trained medical personnel under the supervision of a physician.

Medical	Normal	Abnormal Findings (if any)	Initials
Eyes (Vision)			
Ears, Nose, Throat			
Neck/Lymph Nodes			
Cardiovascular			
Abdomen/Hernias			
Respiratory			
Skin			
Musculoskeletal			
Neurological			
Musculoskeletal/ROM/Strength			
Neck			
Spine/Back			
Shoulders/Arms			
Wrist/Hand			
Hip/Thighs			
Knees/Legs/Ankles			

Allergies:

List any medications taken frequently:

Do you have physical activity limitations? If yes, please explain:

Required Tests

1. 2-step Mantoux TB Skin Test

If reactive a Chest X-ray is required

Date: _____

Result: _____

2. 10 PANEL EXPANDED OPIATE DRUG SCREEN (either urine or blood is acceptable)

Required:

amphetamines, THC, cocaine, opiates, phencyclidine, barbiturates, benzodiazepines,
methaqualone, methadone, propoxyphene

Date: _____

Result: _____

When available, please provide the results of the above testing to the student for submission to the program's Student Upload Portal.

I certify that I have examined and spoken to this patient on this date and found them to be medically qualified to participate both physically and emotionally in the Respiratory Therapy program. I also certify that I am a licensed physician or work directly with a licensed physician.

Print Name _____

Office Address _____

Telephone _____

Signature

Date of Examination

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

Students: Submit this completed form to the Student Upload Portal found on the Respiratory Therapy webpage.