IDEAL SCHOOL OF ALLIED HEALTH CARE

REQUIRED!! MMR TITERS (BLOODWORK)
PPD (TUBERCULOSIS)
10 PANEL URINE DRUG TEST
FLU SHOT (IN SEASON)
COVID VACCINE

PHYSICAL EXAMINATION FORM

Name: _____ Phone: _____
Address: _____
Date of Birth: _____

Consent for Examination & Release of Information

Signature of student: _____ Date: _____

EXAMINATION:

Weight: _____ Height: _____ BP: ___/___ Pulse: _____ Respiration: _____

CONDITION	VISION	HEARING	NOSE	THROAT	HEART	LUNGS
Normal	O	O	O	O	O	O
Abnormal	O	O	O	O	O	O

Explanation: _____

_____

MEDICAL/SURGICAL HISTORY (CHECK ALL THAT APPLY):

O Arthritis	O Head injury	O seizure disorder
O Asthma	O Hearing problems	O Sky diseases/rashes
O Back injury	O Heart Disease	O Surgery
O Chicken pox	O Hepatitis	O Tuberculosis
O Diabetes	O Hernia	O Vision problems
O Dizziness/fainting	O Neck injury	O Weakness/ paralysis
O Fractures	O Psychiatric disorder	O Other

YES, explain: _____

_____

Please indicate any allergies: _____

_____

History of or current Drug/Alcohol abuse: YES or NO
YES, explain: _____

_____
History of or Current Smoking Habits: YES or NO

YES,how much: _____

_____
Please list all medications prescribed on a continuing basis: _____

ALL STUDENTS ARE REQUIRED TO PROVIDE FROM THEIR PHYSICIAN, PROOF OF IMMUNITY OF VACCINATION FOR THE FOLLOWING DISEASES.

1-German Measles
Rubella Vaccine Date _____

Rubella titer Date _____ Result _____

2-Measles
Measles Vaccine
1 ST Dose Date (After 1/1/69)____
2 nd Dose Date (After 1/1/80)____

Measles Titer
Date _____ Result _____

3. MUMPS
Mumps vaccine Date:
--
Mumps Titer Date _____ Result _____

4.Tetanus/Diphtheria
TD Vaccine-required every 10 years
Date _____

5. Hepatitis B
1ST Dose Date: _____
2nd Dose Date: _____
3rd Dose Date: _____
AND
Antibody Titer Date_____ Result _____

6. Meningitis
Meningococcal Vaccine-optional
Date: _____

8. Tuberculosis
Tuberculin Skin Test-(mantoux ppd only)
Date Given_____ (within 12 months)
Date Read_____ (within 72 Hours)
Result N_____ MM_____ P_____ MM____

7. Chicken pox

Varicella Titer Date_____ Result _____
--
Varicella vaccine Date:_____
Varicella vaccine Date:_____

If PPD + obtain CXR
Result _____Date _____
Prophylactic Therapy Medication
Length of Time _____
IGRA -(Quantiferon) Test
Date: _____ Result: _____
(Please attach a copy of the IGRA report including result, test criteria and interpretation

9. 10 Panel Drug test:

TB screening for all students.

1- Unexplained Fever YES_____ NO _____	2- Hoarseness YES_____ NO _____
3- Night Sweats YES_____ NO _____	4- Bloody Sputum YES_____ NO _____
5-Unintentional Weight loss YES____ NO____	6- Have you had INH therapy? YES_____ NO _____
7-Cough YES_____ NO _____	8-Have you ever had a BCG vaccine? YES___ NO ___

I certify that I have conducted a physical examination on the above named person on this date and that he/she is free of any communicable disease and from habituation and addiction to alcohol, narcotics, stimulants, drugs or other substances which may alter behavior. In my professional opinion he/she can adequately perform the functions of a health care provider.

Physician name (print)_____ Date of Exam: _____

Physician Signature: _____ Phone # _____

Address:_____

PLEASE PLACE PHYSICIAN STAMP HERE