Physical Examination (To be completed by a physician or primary healthcare provider.)

Physician or primary healthcare provider: Please review the student's history and complete the physical examination form. The information documented on this form will not be released without the students consent. The purpose of this physical is to determine this person's ability to function in the role of a caregiver.

Name _____
Last *First*

Height _____ Weight _____

Blood Pressure _____ Sex □ M □ F

1. Recommendations for physical activity
□ Unlimited □ Limited

2. Do you have any recommendations regarding the care of this student?
□ No □ Yes (if yes, please explain)
_____
_____
_____

3. Is this student under treatment for any medical or emotional conditions?
□ No □ Yes
_____
_____
_____

4. Are there any disabilities?
□ No □ Yes
_____
_____
_____

_____
Physician's/Care Provider's Name (Please Print)
Facility_____

Address _____

Telephone (_____)_____

_____**Date** _____

Physician's/Care Provider's Signature

Applicants must submit a clean 9 or 10 panel drug test. The drug test can be substituted for a more specific and/or sensitive test. Test may be available at OIAH.

	Normal	Abnormal	Comment
Abdomen			
- Scars			
- Tenderness			
- Masses			
- Liver			
- Spleen			
- Kidneys			
Chest			
- Inspection			
- Pulmonary Findings			
Ears			
- Hearing			
- Canals			
- Drums			
Emotional Stability			
- Evidence of Psychiatric Disorders			
Extremities			
- Reflexes			
- Anatomy & Movement			
- Arms			
- Hands			
- Legs			
- Feet			
Eyes			
- Distant Vision			
- Snellen Chart			
- Corrected			
- Pupils			
- Lids			
- E.O. Muscles			
Color Vision			
Heart			
- Rhythm			
- Thrills			
- Murmurs			
- Blood Pressure			
Neck			
- Thyroid			
- Tremor			
- Speech			
- Motor Paralysis			
Nose-Throat-Gums			
- Dental Repair			
- Pharynx			
- Spine			
Skin Condition			
Nails			
Hair			

Immunization Record (To be completed by a physician or primary healthcare provider.)

Name _____
Last *First* *Middle* *Former name, if applicable*

Today's Date _____ Birth Date _____ Social Security Number _____

All information must be in English. A copy of original immunization record(s) is/are preferred.
Please attach lab reports or numerical results for all positive antibodies

Tetanus-Diphtheria Booster must be within the last ten years. One dose of Tdap is required.
____/____/____ Expires 10 years from date of injection

MMR (Measles, Mumps, Rubella) Either has a report of a positive immune titer for Measles, mumps and Rubella or two doses is required for all students born on or after 01/01/1957.
_____/_____/_____ □ Positive Titer for (each) MMR
_____/_____/_____ □ Dose 1
_____/_____/_____ □ Dose 2

Hepatitis B Three doses of vaccine, reactive Hepatitis B surface antibody lab results, or signed Hepatitis vaccination waiver form is required for all students.
_____/_____/_____ □ Reactive Hepatitis B Surface Antibody
_____/_____/_____ □ Dose 1
_____/_____/_____ □ Dose 2
_____/_____/_____ □ Dose 3
_____/_____/_____ □ Hepatitis waiver

Chicken Pox (Varicella) History of chicken pox, lab report of positive varicella antibody, or two doses of vaccine
_____/_____/_____ □ History of chicken pox
_____/_____/_____ □ Reactive Varicella Antibody
_____/_____/_____ □ Dose 1
_____/_____/_____ □ Dose 2

Two-Step Tuberculosis Screening Skin test (PPD) required regardless of prior BCG inoculation. A skin test expires annually and chest x-rays expire after five years. May be substituted for Interferon Gamma Release Assay.

- **Skin Test**

If skin test is positive, a Chest x-ray must be documented below.
_____/_____/_____ □ Date Given
_____/_____/_____ □ Date Read
_____ Result in mm (if no induration, write '0')

_____/_____/_____ □ Date Given
_____/_____/_____ □ Date Read
_____ Result in mm (if no induration, write '0')

- **Chest X-Ray** (required if PPD skin test is positive):

_____/_____/_____ □ Date of chest x-ray □ Normal □ Abnormal

Influenza *Annual* seasonal Flu Vaccine is required for admission to Clinicals.
_____/_____/_____ □ Date Given/Dose 1

Medical Exemption The student named above does not have one or more of the required immunizations because she/he has a medical problem that precludes the vaccine(s).
_____
_____
_____
_____

Recommended Alternative:
_____
_____

_____
Physician's/Care Provider's Signature

_____
Date

Conscientious Exemption:
I hereby certify by notarization the immunization against _____
is contrary to my conscientiously held beliefs and I understand not receiving all required vaccinations may prevent acceptance into the program.
Subscribed and sworn before me on the _____ day of _____, 20 _____.

_____
Signature of Notary
_____
Date

Notary Stamp Required For Conscientious Exemptions Here