Pasco-Hernando State College

DIVISION OF HEALTH OCCUPATIONS

PHYSICAL EXAMINATION FORM

Students must make personal copies of this form prior to submission; copies will not be provided once they have been submitted.
Please note: This information may be shared with clinical agencies.

Select Program of Study:

_____ Dental Assisting
_____ Emergency Medical Technician (EMT)
_____ Health Unit Coordinator
_____ Human Services
_____ Medical Administrative Specialist
_____ Nursing Assistant
_____ Phlebotomy

COMPLETE ALL OF THE FOLLOWING INFORMATION: (Please type or print legibly in ink.)

Name_____
Last First Middle

Date of Birth_____ Student ID Number _____

Address_____
Street City State Zip

Home Phone (___)_____ Emergency Phone (___)_____

Person to notify in case of emergency_____

THE FOLLOWING IS TO BE COMPLETED BY A LICENSED PRACTITIONER

HEIGHT: _____	**WEIGHT:** _____	**B/P**: _____/_____	**PULSE**: _____
VISUAL ACUITY: Right: 20/ _____	**Left: 20/** _____	**Corrected:** _____ **Yes** _____ **No**	
COLOR VISION: _____ **Normal** _____ **Abnormal**		**HEARING: R** _____ **Normal** _____ **Abnormal** **L** _____ **Normal** _____ **Abnormal**	

Current Medications? (Please list prescription and non-prescription drugs and indicate any precautions necessary.)

_____
_____
_____

Emotional or Physical Conditions that would interfere with student's attendance and progress in campus or clinical settings? (Specify.)

_____
_____
_____

REQUIRED IMMUNIZATIONS/VACCINES AND DIAGNOSTIC/LABORATORY TESTS
(ALL RESULTS MUST BE ATTACHED AND SUBMITTED WITH THIS FORM)

Tetanus/Tdap: Date (within 10 years): _____

OR

Tetanus Titer: Date: _____ Results: _____
Diptheria Titer: Date: _____ Results: _____
Pertussis Titer: Date: _____ Results: _____

2-Step PPD: Date: _____ Date: _____
Results: _____
OR
Chest X-Ray (if PPD positive): Date: _____
Results: _____

Flu Vaccine: Date: _____ (If student elects to decline vaccine, the Influenza Vaccination Declination Form must be submitted.

Hepatitis B Vaccination: Date of Completed Series: _____
OR
Hepatitis B Titer: Date: _____ Results: _____

NOTE: The College supports the recommendations of the American College of Physicians and the Centers of Disease Control (CDC) and strongly encourages the vaccination of students against Hepatitis B in an effort to minimize the risk of Hepatitis B infection to patients, clients, and students. Students declining immunizations, or have not completed the immunization series, will be required to sign the following Student Release Statement:

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring these diseases. At this time, I have elected not to be immunized against Hepatitis B, or I am in the process of being immunized but have not completed the series. I understand that I continue to be at risk of acquiring Hepatitis B or other infectious diseases until I have completed the immunization series.

_____ _____ _____
Student Signature Student ID Number Date

I certify that I have examined the student and have found him/her to be in good mental and physical condition and capable of performing all essential functions required of the program of study selected.

_____ _____
Signature of Practitioner **Date**

_____
Print - Name of Practitioner

Address: _____
Street **City** **State** **Zip**

Phone: ( )_____