STUDENT HEALTH INFORMATION

Required to be completed and returned to the Administration Office <u>before the first day of class.</u>

Name : _____

Are you taking medications? Yes No If yes, give names and dosages:

_____ _____

_____ _____

Have you ever had a Tuberculosis (skin) Test? Yes No

If "Yes", did the area become red or swollen? Yes No

I, the undersigned, certify that the above answers are true and correct and I give the examining physician, permission to submit a report to the Clinical Site.

Signature: _____ **Date:** _____

Printed Name: _____

THE FOLLOWING IS TO BE COMPLETED BY EXAMINING PHYSICIAN OR NURSE PRACTITIONER.

<u>Systems Review:</u>	**<u>Comments:</u>**
Head	
Eyes/Ears/Nose/Throat	
Nodes	
Heart	
Lungs	
Abdomen	
Hernias	
Back	
Skin	
Gait/Posture/Squat	
R O M	
Extremities	

Vital Signs: B/P:_____/_____P:_____R:_____T:_____Height:_____Weight: _____

TB SKIN TEST:

Date given: Date read:

___ _/_ _ /_ _ __ _____/_____/_____ **Result: ☐ Positive ☐ Negative**

Month Day Year Month Day Year

Chest X-ray (required if TB skin test is positive) **D**ate: ____/_ _ _/_ _ _ **Result: ☐ Positive ☐ Negative**

Month Day Year

I certify that this individual is sufficiently free of disease to perform assigned duties and does not have any health condition that would create a hazard for him/herself, fellow employees, or residents or visitors

Physician Signature_____**Date**_____

Print Physician Name_____