Student ID #_____

Physical Examination Form

Southeast Tech
Health and Human Services Programs
Sioux Falls, SD

THIS FORM MUST BE COMPLETED WITHIN ONE YEAR
PRIOR TO GOING TO CLINICAL OR INTERNSHIP

A physical examination is important for students enrolled in the various Health and Human Services programs to provide evidence that they can meet the demands of their profession without hazard to themselves and others.

Student Name: _____
Last First Middle

Social Security Number: XXX - XX - _____ _____ _____ _____

Southeast Tech Program _____

MEDICAL HISTORY (Please check all that apply)

Does the student have a history of:

___ Asthma
___ Chronic cough
___ COPD
___ Allergies (include latex)
___ Tuberculosis
___ Emotional disturbances
___ Weak back/back surgery
___ Pregnancies/miscarriage
___ Sinusitis
___ Diabetes Mellitus
___ Polyuria
___ Seizure disorders
___ Unexplained syncope
___ Frequent headaches
___ GI disorder
___ Chicken Pox (Varicella)
___ Smoking
___ Fallen Arches
___ Alcoholism
___ Drug addiction
___ Drug allergies
___ Hemorrhoids
___ Hernia
___ Thyroid disorder
___ Urticaria
___ Varicose veins

Please provide information concerning any boxes checked:

_____
_____
_____
_____
_____
_____
_____
_____

Present Medications:

_____
_____
_____
_____
_____

Allergies: _____

Reactions: _____

Latex Advisory

In addition, the individual has been advised of exposure to latex/latex-based products in health care environments and the associated potential health risks for individuals with sensitivities or allergies.

PHYSICAL EXAMINATION

Date of Birth: _____/_____/_____ Height: _____ Weight: _____
T/P/R: _____/_____/_____BP: _____/_____
Vision Acuity: _____Vision Corrected: 20/_____ (L) 20/_____ (R)
Color Blindness: _____
HEENT: _____ Hearing Assessment: _____
Cardiopulmonary: _____Neurological:_____
Abdominal: _____Musculoskeletal: _____
Back: _____ Rectal/GU: _____
General: _____
List any physical limitations noted: _____
_____

Certificate of Good Physical Health and Latex Exposure Counseling Statement

I have reviewed the information in this form, including medical diagnoses (if any) and medications (if any) and found:

_____ Suitable for _____
(Name of student) (Name of health program)

☐ Check box if you would recommend re-evaluation for a change of health program.

_____ _____ _____
Examiner's Signature **Examiner's Name (Print)** **Date**

Licensed as a (circle one): MD DO PA ARNP CNP CNM

License Number: _____State/Country Licensed: _____

Telephone: ( ) _____

Address: _____
Street City State Zip

***Attention Southeast Tech Student: Return this completed form to Clorinda Beitelspacher, Affiliate Coordinator located Health Science Center, Office HC200D, FAX 605-367-6108 or scan to Clorinda.beitelspacher@southeasttech.edu**

Student ID # _____

Required Immunizations

Southeast Tech
Health and Human Services Programs
Sioux Falls, SD

Student Name: _____
Last First Middle
Social Security Number: __XXX__ - __XX__ - ___ ___ ___ ___
Southeast Tech Program _____

Mandatory Immunizations (If not performed at the time of the physical exam, documentation is required)

❖ Tuberculosis (TB) Test (within past year) - *ONE* of the following

2-Step PPD (mantoux) Tuberculosis (TB) Test (within past year)
Date of 1st test: _____ Results:_____
Date of 2nd test: _____ Results: _____

OR

QuantiFERON Gold blood draw
Date _____ Results: _____

If positive, documentation of treatment and proof of inactive status is required. *If know converter,* ***chest x-ray less than twelve (12) months old*** *upon entry into clinical with completion of a Center for Disease Control (CDC) TB Questionnaire annually thereafter.*

❖ MMR (Measles, Mumps, Rubella) - *ONE* of the three options

Have **2 doses** MMR vaccine**:** Date: _____ Booster Date: _____

OR

Have proof of adequate measles titer Date: _____ Results: _____
Have proof of adequate mumps titer Date: _____ Results: _____
Have proof of adequate rubella titer Date: _____ Results: _____

(if titer completed attach copy of lab results)

OR

Has a physician-documented case of measles Date: _____
Has a physician-documented case of mumps Date: _____
Has a physician-documented case of rubella Date: _____

❖ FLU Vaccination (Required during Flu season) -Current seasonal flu vaccination

Date vaccinated: _____

❖ Chicken Pox (Varicella) - *ONE* of the following

Have proof of adequate Varicella titer ***(attach copy of titer lab results)***

Date: _____ Results: _____

OR

Have **2 doses** of Varicella vaccine

Dates: 1st _____ 2nd_____

❖ Tetanus and Diphtheria (Tdap)

Date: Initial_____ Most Recent Booster_____

vaccination must be within the last 10 years

❖ Hepatitis B (HBV) – *ONE* of the following

Have proof of adequate Hepatitis B titer ***(attach copy of titer lab results)***

Date: _____ Results: _____

OR

Have **3 doses** of Hepatitis B vaccine

Dates vaccinated:

#1_____#2_____#3_____

_____ _____ _____

Examiner's Signature **Examiner's Name (Print)** **Date**

Licensed as a (circle one): MD DO PA ARNP CNP CNM

License Number: _____State/Country Licensed: _____

Telephone: ( ) _____

Address:

_____

Street City State Zip

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