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**