Oakton College

Health Services

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Health Career Physical Examination Report

Program _____

Name _____ Date of Birth _____ Phone _____

Address _____ City _____ State _____ Zip _____

OFFICE USE ONLY

PHYSICAL FINDINGS – To be completed by a licensed health care provider. Form must be stamped (below) and a box checked if the student is (or is not) medically cleared.

Physical Examination

Ht. _____ Wt. _____ B/P _____ Pulse _____ **Required:** Vision L 20/_____ R 20/_____

Corrective Lenses ❑ Yes ❑ No

Medical history _____ Allergies _____

Surgical history _____ Family history _____

Medications _____ Social history _____

Are there any abnormalities in the following areas?

	NO	YES	If yes, please describe.		NO	YES	If yes, please describe.
Cardiovascular	❑	❑	_____	Musculo-Skeletal	❑	❑	_____
Eye	❑	❑	_____	Neurological	❑	❑	_____
Ear/Nose/Throat	❑	❑	_____	Respiratory	❑	❑	_____
Abdominal	❑	❑	_____	Skin	❑	❑	_____
Hearing	❑	❑	_____	Lymph Nodes	❑	❑	_____

Health risk issues addressed (smoking, drinking, drug use, safer sex) _____

_____

Summary of findings/comments _____

_____

❑ Student is medically cleared for the Health Career program without limitations.

❑ Student is **not** medically cleared for the Health Career program.

Health care provider signature _____ **Date** _____

Address _____

City *State/Zip*

Phone number _____

Office Stamp

Program_____

Name _____ Date of Birth _____

Students may be medically cleared without presenting the proof of vaccinations at appointment.

Tuberculosis (TB)
PPD skin test annually; **if positive, a Quantiferon Gold blood test is required and must be attached.**

Skin Test: Date given _____ Date read _____ Result _____ mm

Vaccine MFG and Lot # _____ Exp. date _____

Administered by _____

2-step: Date given _____ Date read _____ Result _____ mm

Vaccine MFG and Lot # _____ Exp. date _____

Administered by _____

Chest x-ray: Date _____ Result ❑ Positive ❑ Negative

Hepatitis B

Has the student had the hepatitis B vaccine series? ❑ No ❑ Yes

If Yes, please provide documentation of dates 1. _____ 2. _____ 3. _____

Tdap

Date of Tdap vaccine: _____

NO student will be allowed to attend clinical classes until health forms are completed and returned to Health Services.
