AUSTIN COMMUNITY COLLEGE DISTRICT

Health Data Form / Physical Exam

Indicate program of application:

- ☐ Associate Degree Nursing – Traditional Track
- ☐ Associate Degree Nursing – Mobility Track
- ☐ Associate Degree Nursing – Alternative Track
- ☐ Dental Hygiene
- ☐ Diagnostic Radiology Programs
- ☐ Diagnostic Sonography Programs
- ☐ Emergency Medical Services
- ☐ Health Information Technology
- ☐ Medical Lab Technician
- ☐ Molecular Diagnostics
- ☐ MRI
- ☐ Occupational Therapy Assistant
- ☐ Personal Fitness Trainer
- ☐ Pharmacy Technician
- ☐ Phlebotomy
- ☐ Physical Therapist Assistant
- ☐ Surgical Technology
- ☐ Vocational Nursing

Applicant information:

Last Name	First Name	MI	Maiden

Address	Apt.#	City	State	Zip

Date of Birth	Social Security Number or Student ID
Phone	**ACC E-mail**

Person to notify in case of emergency:

Full Name	Relationship

Address – Number & Street

City	State	Zip

Home Phone	Work Phone

Student Signature

Certain minimum physical abilities and characteristics are required in health sciences professions. See program web page for specific requirements. Are you able to meet the minimum technical skills standards for the program to which you are applying?

☐ Yes ☐ No

If no, explain:

The following must be completed by a physician, physician's assistant or nurse practitioner:

General Information:				
Gender: ☐ Male ☐ Female	Height (inches)	Weight (lbs)	Blood Pressure	Pulse

Identify any problems in the following:			
Head, ears, nose, throat	☐ Yes or ☐ No	Genitourinary	☐ Yes or ☐ No
Respiratory	☐ Yes or ☐ No	Musculoskeletal	☐ Yes or ☐ No
Cardiovascular	☐ Yes or ☐ No	Metabolic/Endocrine	☐ Yes or ☐ No
Gastrointestinal	☐ Yes or ☐ No	Neurological	☐ Yes or ☐ No
Hernia	☐ Yes or ☐ No	Skin	☐ Yes or ☐ No
Eyes	☐ Yes or ☐ No	Psychiatric/Emotional	☐ Yes or ☐ No

If problems are present, would they create a limitation in health care delivery? ☐ Yes ☐ No
See program specific technical standards.

Explain:

Tuberculosis: **must show proof of:**	
A. Tuberculin Skin Test: **REQUIRED ANNUALLY OR**	Date Given: ____________________ ☐ Positive ☐ Negative Read by: ____________ Date: ________
B. Chest X-ray (required **IF** skin test is positive) Must provide signed documentation of results	Date: ____________________ X-ray results: ________________

Physician, Physician's Assistant or Nurse Practitioner Information:		
Printed Name		
Address		
Signature	Credentials	Date