

Health Data Form / Physical Exam

Indicate program of application:	
<input type="checkbox"/> Associate Degree Nursing – Traditional Track	<input type="checkbox"/> Molecular Diagnostics
<input type="checkbox"/> Associate Degree Nursing – Mobility Track	<input type="checkbox"/> MRI
<input type="checkbox"/> Associate Degree Nursing – Alternative Track	<input type="checkbox"/> Occupational Therapy Assistant
<input type="checkbox"/> Dental Hygiene	<input type="checkbox"/> Personal Fitness Trainer
<input type="checkbox"/> Diagnostic Radiology Programs	<input type="checkbox"/> Pharmacy Technician
<input type="checkbox"/> Diagnostic Sonography Programs	<input type="checkbox"/> Phlebotomy
<input type="checkbox"/> Emergency Medical Services	<input type="checkbox"/> Physical Therapist Assistant
<input type="checkbox"/> Health Information Technology	<input type="checkbox"/> Surgical Technology
<input type="checkbox"/> Medical Lab Technician	<input type="checkbox"/> 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:

NAME: _____

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

General Information:				
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height (inches)	Weight (lbs)	Blood Pressure	Pulse

Identify any problems in the following:			
Head, ears, nose, throat	<input type="checkbox"/> Yes or <input type="checkbox"/> No	Genitourinary	<input type="checkbox"/> Yes or <input type="checkbox"/> No
Respiratory	<input type="checkbox"/> Yes or <input type="checkbox"/> No	Musculoskeletal	<input type="checkbox"/> Yes or <input type="checkbox"/> No
Cardiovascular	<input type="checkbox"/> Yes or <input type="checkbox"/> No	Metabolic/Endocrine	<input type="checkbox"/> Yes or <input type="checkbox"/> No
Gastrointestinal	<input type="checkbox"/> Yes or <input type="checkbox"/> No	Neurological	<input type="checkbox"/> Yes or <input type="checkbox"/> No
Hernia	<input type="checkbox"/> Yes or <input type="checkbox"/> No	Skin	<input type="checkbox"/> Yes or <input type="checkbox"/> No
Eyes	<input type="checkbox"/> Yes or <input type="checkbox"/> No	Psychiatric/Emotional	<input type="checkbox"/> Yes or <input type="checkbox"/> 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:	
<p>**See excerpt from CDC website below from <u>Latent Tuberculosis Infection</u></p> <p>A. Documentation of a negative (<10mm) two-step tuberculin skin test within the past 90 days prior to beginning the Program</p> <p>OR</p>	<p>Date Given: #1 _____</p> <p><input type="checkbox"/> Positive <input type="checkbox"/> Negative (If negative, repeat in 1- 3 weeks)</p> <p>Read by: _____ Date: _____</p> <p>Date Given: #2 _____</p> <p><input type="checkbox"/> Positive <input type="checkbox"/> Negative</p> <p>Read by: _____ Date: _____</p>
<p>B. Negative blood assay (QFT, TSPOT) within the past 90 days prior to beginning the Program</p> <p>OR</p>	<p>Date: _____</p> <p>Result: _____</p>
<p>C. If a prior positive reactor to skin testing, a negative chest x- ray within 5 years and free of productive cough, night sweats, or unexplained loss of weight</p>	<p>Date: _____</p> <p>X-ray results: _____</p>

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

** This is required by our clinical agencies – no exceptions. “Some people infected with *M. tuberculosis* may have a negative reaction to the TST if many years have passed since they became infected. They may have a positive reaction to a subsequent TST because the **initial** test stimulates their ability to react to the test. This is commonly referred to as the “booster effect” and may incorrectly be interpreted as a skin test conversion (going from negative to positive). For this reason, the “two-step method” is recommended at the time of initial testing for individuals who may be tested periodically (e.g., health care workers).”