BROOKHAVEN COLLEGE:
HEALTH & HUMAN SERVICES
PHYSICAL EXAM & IMMUNIZATION RECORD

Date: ____________________

Name: ____________________ D.O.B. ____________________
Address: ____________________
Phone home: ____________ Mobile: ____________ Work: ____________
Email: ____________________

Health Questionnaire: To be completed by applicant:

_____ Yes _____ No Do you have any physical limitations that would affect your ability to lift, turn or transfer patients?

_____ Yes _____ No Do you have any limitations in use of your senses, such as in sight or hearing, which would limit your ability to practice a health profession?

_____ Yes _____ No Do you have any other condition that might interfere with your ability to practice in the health professions?

If you answered "yes' to any of the above, please explain you limitations in detail on a separate sheet of paper.

List any medications you take on a regular basis or on a frequent basis this past year:

____

____

Tuberculosis Screening: Documentation must be submitted: requires a physician's signature or verification form the Health Center.
Intradermal PPD(Mantoux) – within six months unless previously positive
Date: _________ Induration:_______ Results: ________
Physician/Nurse Practitioner signature __________________________
Chest X-ray within one year if PPD is positive
Date: _________ Results: ________
Physician/Nurse Practitioner signature __________________________

History: Include any significant information regarding previous medical surgical, psychiatric conditions and use of alcohol and /or drugs.

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General Appearance:

Height:	Weight	B/P
Date of last visual exam:	Glasses	Corrective Lenses:

Normal	Check each item in appropriate column	Abnormal	Describe abnormality in detail, attaché sheet if necessary
	Eyes, ears, nose, and throat		
	Mouth, teeth, neck		
	Thyroid		
	Heart & vascular		
	Lungs		
	Abdomen & viscera		
	Hernia		
	Scars		
	Neck & vertebrae		
	Genitalia		
	Pelvis with pap smear: if indicated		
	Rectal, anus: if indicated		
	Extremities		
	Skin		
	Neurological		

Laboratory Data: Specific lab findings, or antibody titers

Name of Test: **Date:** **Results:**

Required Immunizations:
Dates of immunizations and dates of lab results indicating seropositivity required. Each immunization line requires a physician's or nurse practitioner's signature of verification from a clinic or health center.

Immunizations	Date of completed series	Seropositivity—titer lab results, if done	Physician/Nurse Practitioner Signature
Measles: two doses since 12 months of age, if born after Jan 1, 1957			
Mumps: two doses since 12 months of age, if born after Jan 1, 1957			
Rubella: two doses since 12 months of age			
Varicella: Two doses are required, if one dose was received before the age of 13, then only one dose is required. Confirmation via a notarized statement signed by physician/ parent/ guardian of Varicella disease may be accepted.			
Tetanus/Diphtheria/Pertussis: One dose within past 10 years.			
Hepatitis B Series:			
o Initial			
o Second Dose			
o Third Dose			
Other immunizations as required by clinical agency			

**Physician/nurse practitioner waiver may be extended for certain medical conditions (i.e. pregnancy), but must be documented.*

Note: *Physical exam form will not be accepted without doctor's signature or health center verification for each immunization. TB screening, PPD, MMR*
TDAP & HBV immunizations are available at the Brookhaven College or Mountain View College Health Center by appointment. No student may begin clinical rotation without verification of immunization status.

PHYSICIAN RECOMMENDATIONS:

Yes *No* ______ Based upon your physical examination, is the applicant free of any restrictions in his/her ability to turn or move heavy objects? If "No" describe

Yes *No* ______ Is the applicant able to see and hear adequately to practice a health care profession? ? If "No "please explain:

Yes *No* ______ Is the applicant free of any pathological conditions either physical or mental that would interfere with the practice of a health profession? If "No" please describe:

Signature of Physician/ Nurse Practitioner *Date*

Address:

Additional comments: