Student Medical Exam Form

Program: (check one) ☐ HIT ☐ MA ☐ MLT ☐ NE ☐ PTA ☐ RT ☐ RC ☐ Other ______________

Return by program designated deadline:

Southwestern Illinois College - **Health Sciences**
2500 Carlyle Ave • Belleville, IL 62221 • Fax: (618) 235-2052

Section 1 – Personal Information

Student completes this section.

Student Name (last, first, middle): ______________________________

Street Address: ______________________ Phone Number: ______________________

City, State, Zip: ______________________ Date of Birth: ______________________

Section 2 – Medical History

Student completes this section. Medical examiner is encouraged to discuss with student.

Check all that apply – use the space below to provide details:

- ☐ Heart disease or heart attack
- ☐ Heart murmur or Arrhythmia
- ☐ Fainting/dizziness
- ☐ Diabetes (specify control method)
- ☐ Thyroid disease
- ☐ Eye disorder/vision loss
- ☐ Ear disorder/hearing loss
- ☐ GERD, Chron's disease, IBS, etc
- ☐ Any allergic reaction (drug, food, product, latex, etc)
- ☐ Skin disease
- ☐ Back injury, scoliosis or chronic lower back pain
- ☐ Arthritis
- ☐ Orthopedic disorder
- ☐ Mental disorder/emotional instability
- ☐ Head injury
- ☐ Stroke or paralysis
- ☐ Headaches/migraines
- ☐ Neurological disorder
- ☐ Seizure disorder/Epilepsy
- ☐ Depression
- ☐ Shortness of breath, asthma, cough or hoarseness
- ☐ Pulmonary disease
- ☐ Tuberculosis
- ☐ Cancer (specify type)
- ☐ Abnormal bleeding
- ☐ Major Surgery
- ☐ Other ______________________
- ☐ Other ______________________

Provide details from all boxes checked above (attach additional sheets if more room is needed):

____

____

____

____

List any current medications or treatments (attach additional sheets if more room is needed):

____

____

____

Revised 10/29/2010

Section 3 – Physical Examination

Medical Examiner (MD, DO, ARNP or PA) completes this section.

Height: ______________ Weight: ________________ Blood pressure: ________________ Pulse: _______________

System:	Normal	Abnormal/Surgery (explain - attach additional sheets if more room is needed)
Cardiovascular	☐	☐ ______________________________
Endocrine/Metabolic	☐	☐ ______________________________
Eyes/Ears/Nose/Throat	☐	☐ ______________________________
Gastrointestinal	☐	☐ ______________________________
Genitourinary	☐	☐ ______________________________
Integumentary	☐	☐ ______________________________
Musculoskeletal	☐	☐ ______________________________
Neurological	☐	☐ ______________________________
Respiratory	☐	☐ ______________________________

Section 4 – Immunizations and Tests – MUST COMPLETE

Medical Examiner completes this section.

A **Two Step Tuberculosis Screening:** (Nursing students with proof of annual screenings need Step 1 only.) **Attach chest x-ray if any result is positive.**

Step 1 date: ____/____/____ Results: POS / NEG Step 2 date: ____/____/____ Results: POS / NEG

B **Tetanus:** Must be within 10 years

Date: ____/____/____

C **Polio Vaccine:** Date 1: ____/____/____ Date 2: ____/____/____

Date 3: ____/____/____ Date 4: ____/____/____

D **Measles, Mumps and Rubella:** Lab results for all titers must be attached if vaccine was not administered. Immune:

MMR Vaccine dose 1: ____/____/____

MMR Vaccine dose 2: ____/____/____

(NE program requires Rubella Titer with vaccine.)

OR

Measles Titer: ____/____/____ ☐ Yes ☐ No

Mumps Titer: ____/____/____ ☐ Yes ☐ No

Rubella Titer: ____/____/____ ☐ Yes ☐ No

E **Varicella (Chicken Pox):** Indicate disease **or** titer **or** vaccine. ☐ Disease was contracted. (Requires clinical confirmation)

☐ Varicella Titer (attach lab results) Immune: Yes / No ☐ Vaccine Dose 1: ____/____/____ Dose 2: ____/____/____

F **Hepatitis B Vaccine Series:** **This vaccination series is optional with student waiver for all programs EXCEPT for MLT and RC.**

Student must start the 3 dose process (complete at least one dose) **OR:** ☐ Student declines vaccine (MLT & RC students may NOT decline)

Dose 1 completed: ____/____/____ Dose 2 completed: ____/____/____ Dose 3 completed: ____/____/____

Medical Examiner: Please complete

I verify that I have reviewed this completed form with the student. I consider this student:

☐ Mentally and physically able to undertake this program. ☐ Not mentally and physically able to undertake this program.

Signature: ______________________ Printed Name: ______________________ Date: ______________

Office Address: ____

Office Phone: ______________________________

Student: Read, Sign and Date

The information I have provided is complete and accurate to the best of my knowledge and I have attached all laboratory results.
I understand that failure to complete this form correctly may jeopardize my participation in the clinical portion of this program.

Signature: ______________________ Printed Name: ______________________ Date: ______________