

Student Medical Exam Form

Program: HIT MA MLT NE PTA
(check one) 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:

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

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	<input type="checkbox"/>	<input type="checkbox"/> _____
Endocrine/Metabolic	<input type="checkbox"/>	<input type="checkbox"/> _____
Eyes/Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/> _____
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/> _____
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/> _____
Integumentary	<input type="checkbox"/>	<input type="checkbox"/> _____
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/> _____
Neurological	<input type="checkbox"/>	<input type="checkbox"/> _____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/> _____

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: ____ / ____ / ____
(Not Required for RT) 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: ____ / ____ / ____	OR	Measles Titer: ____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> No
MMR Vaccine dose 2: ____ / ____ / ____		Mumps Titer: ____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> No
(NE program requires Rubella Titer with vaccine.)		Rubella Titer: ____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> 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: ____ / ____ / ____

G Influenza: Annual flu shot is **REQUIRED** for RT program students when it becomes available.**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: _____