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:

- ☐ 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):

_____

_____

_____

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:** **(Not Required for RT)**
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.

MMR Vaccine dose 1: ___/___/___
MMR Vaccine dose 2: ___/___/___
(NE program requires Rubella Titer with vaccine.)

OR

Measles Titer: ___/___/___ Immune: ☐ Yes ☐ No
Mumps Titer: ___/___/___ Immune: ☐ Yes ☐ No
Rubella Titer: ___/___/___ Immune: ☐ 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: ___/___/___

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

H **COVID-19 Vaccine:**	**Product Name/Manufacturer:**	**Date:**	
1st Dose		/ /	
2nd Dose *(if applicable)*		/ /	
Booster		/ /	**Attach lab results**

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:_____