MA Program Student Medical Exam Form

Return by designated deadline: Southwestern Illinois College – MA Program • 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: ______________________

SWIC Student Email Address: ______________ . ______________ @student.swic.edu

Emergency Contact:

Name: ______________________ Relationship: ☐ Spouse ☐ Parent ☐ Other: ____________

Phone: ______________________

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):

____

____

____

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: ____________

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 – Tests/Immunizations – ALL SECTIONS IN WHITE MUST BECOMPLETED

Medical Examiner completes this section.

A Tuberculosis Screening: Attach chest x-ray if ANY result is positive.

Date: ________/______/________ Results: ☐ Neg ☐ Pos

B

Tdap date: __________/__________/__________

(Tetanus/Diphtheria & Pertussis)

One time dose of Tdap required. Tdap valid for 10 years.

Td or Tdap booster date: _________/_________/_________

(Tetanus/Diphtheria and/or Pertussis)

Boosters required every two years following initial Tdap 10 year period.

C Polio Vaccine dates:

1: __________/_____/__________

2: __________/_____/__________

3: __________/_____/__________

OR ☐ Titer *(Attach lab results)*

Immune: ☐ Yes ☐ No

D Measles, Mumps and Rubella:

MMR Vaccine dose 1: ______/______/______

MMR Vaccine dose 2: ______/______/______

OR

(Attach lab results for all titers)

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

E Varicella (Chicken Pox): Indicate disease **or** vaccine **or** titer.

☐ **Disease** was contracted. *(If box checked; MD signature below acts as confirmation.)*

OR

☐ **Vaccine:** Dose 1: _____/_____/_____ Dose 2: _____/_____/_____

OR

☐ **Titer**: *(Attach lab results)*

Immune: ☐ Yes ☐ No

F Hepatitis B Vaccine Series: Student must start the 3 dose process (complete at least one dose) by designated date.

1:________/_____/________ (Dose 1 started by designated due date of medical exam)

2:________/_____/________ (1 month after dose 1)

3:________/_____/________ (5 months after dose 2)

OR ☐ **Titer**: *(Attach lab results)*

Immune: ☐ Yes ☐ No

G Influenza: Annual flu shot is required after it becomes available. Due by October 30th, annually.

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 Name/Address/Phone: