

MLT Program Student Medical Exam Form

Return by designated deadline: Southwestern Illinois College – MLT 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: _____ @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:

- | | |
|--|---|
| <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):

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	<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 – Tests/Immunizations – ALL SECTIONS IN WHITE MUST BE COMPLETED*Medical Examiner completes this section.***A Tuberculosis Screening:** Attach chest x-ray if ANY result is positive.Date: ____ / ____ / ____ Results: Neg Pos**B Influenza (Flu shot):** Date: ____ / ____ / ____

Lot#: _____ Provider: _____

C Tdap date: ____ / ____ / ____

(Tetanus/Diphtheria & Pertussis) One time dose of Tdap required.

Td booster date: ____ / ____ / ____

(Tetanus/Diphtheria) After Tdap, Td booster within 2 years.

D Polio Vaccine dates: 1: ____ / ____ / ____

2: ____ / ____ / ____ 3: ____ / ____ / ____

OR Titer Immune:
(Attach lab results) Yes No**E Measles, Mumps and Rubella:***(Attach lab results for all titers)*

MMR Vaccine dose 1: ____ / ____ / ____

MMR Vaccine dose 2: ____ / ____ / ____

OR

Measles Titer: ____ / ____ / ____

Mumps Titer: ____ / ____ / ____

Rubella Titer: ____ / ____ / ____

Immune:
 Yes No
 Yes No
 Yes No**F 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:** Immune:
(Attach lab results) Yes No**G Hepatitis B Vaccine Series:** Student must start the 3 dose process (complete at least one dose) by designated date.

Immune:

1: ____ / ____ / ____ 2: ____ / ____ / ____ 3: ____ / ____ / ____
(Dose 1 started by designated due date of medical exam) (1 month after dose 1) (5 months after dose 2)**OR** **Titer:** Yes No
(Attach lab results)

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

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: _____ / _____ / (____) _____ - _____