SPOKANE COMMUNITY COLLEGE
HEALTH SCIENCE PROGRAMS
1810 N GREENE STREET, MS 2090
SPOKANE WA 99217

PHYSICAL EXAMINATION – (Student completes this side)

Name: _____ Program: _____

Address: _____ Date of Birth: _____

Day Phone: _____ Evening Phone: _____ Cell Phone: _____

Please list all current medications: _____

_____

_____

_____

1. Have you ever had or do you now have any of the following:

- Heart Problems (including murmurs) Yes No
- Persistent gastrointestinal problems
  (for example: colitis, ulcers) Yes No
- Headaches, frequent or severe Yes No
- Back injury Yes No
- Diabetes Mellitus Yes No
- Epilepsy or seizures Yes No
- Hepatitis
  (If so, when _____) Yes No
- Allergies or other immune system
  problems Yes No
- Reproductive Organ problems Yes No
- Foot problems Yes No
- Chicken Pox Yes No

2. Please comment on any health condition that might prevent you from completing your chosen program (for example, inability to perform certain motions, back injury, etc.) PLEASE NOTE: All Health Science Programs require lifting, standing and some degree of stress.

_____

_____

_____

_____

3. HUMAN IMMUNODEFICIENCY VIRUS (HIV) antibody test is not required for program entrance. Students who are, or have been exposed to potentially contaminated blood or other body fluids are encouraged to discuss the need for testing and counseling with their health care provider or the Spokane County Health District staff.

Please have your health care provider complete this section.

4. Height: _____ Weight: _____ B.P.: _____ (sitting)

   Visual Acuity:

   Uncorrected: R _____ L _____ Corrected: R _____ L _____

   Hearing (whisper at 5 ft):

   R _____ L _____

   HEENT:

   Cardio-respiratory:

   Musculo-skeletal:

   Gastrointestinal:

   Neurological (including speech):

   Genitourinary:

   Other:

5. Laboratory (**Required)**

   Urinalysis: Alb _____ Sugar _____ Blood _____

   Pap smear (voluntary) _____

   Blood work (only if indicated) _____

6. Medical Recommendations:

   _____ No significant restriction for applied program

   _____ Limitation and suggested restrictions: _____

_____

_____

Signature of Healthcare Provider (**Required)** Title

Address of medical clinic or office (**Required):** _____

Phone of medical clinic or office (**Required):** _____

Date of physical exam (**Required):** _____

Note: ***<u>Only an</u>*** ***<u>original physical form</u>*** *will be accepted (you may want to make a copy for your records). It must contain an original healthcare provider signature, medical facility address, phone number, and date of examination.*

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IMMUNIZATION RECORD

Name: _____ Program: _____

Address: _____ Date of Birth: _____

Day Phone: _____ Evening Phone: _____ Cell Phone: _____

- Two (2) Complete Tuberculin Tests:
  (Documentation showing 2 tests within the past 12 months will be accepted)

  Test 1: Date administered: _____ Provider initials: _____

  Date read: _____ Results: _____ Provider initials: _____

  Test 2: Date administered: _____ Provider initials: _____

  Date read: _____ Results: _____ Provider initials: _____

  IF POSITIVE

  Chest X-ray:

  Date administered: _____ Provider initials: _____

  Results: _____ Provider initials: _____

  ****Note: If a positive reading results you must provide proof of chest x-ray or completed treatment****

- Hepatitis B

  First Dose: Date administered: _____ Provider initials: _____

  Second Dose: Date administered: _____ Provider initials: _____

  Third Dose: Date administered: _____ Provider initials: _____

  Immunity Confirmation by Titer: Date administered:_____
  OR
  Hep B booster date: _____

  Immunity by titer: Date administered: _____ Provider initials: _____

  OR

  Signed waiver Date signed: _____

- Measles/Mumps/Rubella (MMR Vaccination)
  2 doses required after the age of 1 year; at least 1 month apart
  Documentation showing immunizations given will be accepted

  First Dose: Date administered: _____ Provider initials: _____

  Second Dose: Date administered: _____ Provider initials: _____

  OR

  You may have a **TITER** to prove immunity if no records can be found.
  Titer **must** show immunity for
  Measles (Rubeola) **AND** Mumps **AND** Rubella.

  Measles (Rubeola): Date of Titer: _____ Provider initials: _____

  Mumps: Date of Titer: _____ Provider initials: _____

  Rubella: Date of Titer: _____ Provider initials: _____

- Varicella (Chicken Pox) Vaccination
  Required: 2 doses of vaccine after the age of 1 year; at least a month apart.

  First Dose: Date administered: _____ Provider initials: _____

  Second Dose: Date administered: _____ Provider initials: _____

  Immunity by titer: Date administered: _____ Provider initials: _____

  OR

  You may have a **TITER** to prove immunity if no records can be found.
  Titer **must** show immunity for
  Varicella (Chicken Pox)

  Varicella Date of Titer: _____ Provider initials: _____

- TDaP
  Tetanus Diphtheria and Pertussis
  (Documentation showing immunization given within 10 years will be accepted)

  Date administered: _____ Provider initials: _____

- Influenza

  Date administered: _____ Provider initials: _____

OR

Signed waiver

Date signed: _____

I hereby authorize the Health Care Provider to release all information to the Spokane Community College, Health Sciences Division, 1810 N Greene St MS 2090, Spokane WA 99217.

_____ _____

Student Signature Date