



**ALLIED HEALTH DIVISION  
STUDENT HEALTH RECORDS**

**PHYSICAL EXAMINATION**

Student's Name: \_\_\_\_\_

Name of Program: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Pre-existing / Chronic Conditions: \_\_\_\_\_

*(Please note: For any conditions which would, in any way, restrict, limit, or be aggravated by students clinical rotations, including pregnancy, an additional and separate physician's release form are required to be attached to this form.)*

Current Medications: \_\_\_\_\_

I certify that the above student was given a physical examination and is qualified to enter College of the Canyons Allied Health Program. I realize the program includes clinical experience in a hospital as well as classroom lectures for several hours at a time.

I also certify that the above student is sufficiently free of disease to perform assigned duties and does not have any health condition that would create a hazard for herself/himself, fellow students, patients, or visitors.

Physicians Signature \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_

**Note: PHYSICAL MUST BE GIVEN NO MORE THAN SIX MONTHS BEFORE START OF PROGRAM.**

Student Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

As a part of the physical examination, or documented history, the above person has the following proof of immunization and titers showing proof of immunity. **(Please note: Titers must be drawn and documented--it is not sufficient to say that they had the disease).**

**T.B. Clearance:** Must have PPD (annually)

TB test	Chest X-Ray
Applied: ____/____/____ Given by: (Initial)_____	Date of Exam ____/____/____
Reading: ____/____/____ Read by: (Initial)_____	Date of Results ____/____/____
<input type="checkbox"/> Negative <input type="checkbox"/> Positive	<input type="checkbox"/> Normal Reading <input type="checkbox"/> Positive TB
**If results are positive, get referral for chest x-ray from MD**	MD Signature _____
	Date Signed _____

**Must have documentation of positive titers (blood test) AND all vaccinations!!!**

**Hepatitis B\*** NOTE: MUST BEGIN VACCINE SERIES BY START OF PROGRAM

Dose No. 1 (date) \_\_\_\_\_

Dose No. 2 (date) \_\_\_\_\_

Dose No. 3 (date) \_\_\_\_\_

Titer Results:     Positive     Negative    Read by (initial) \_\_\_\_\_

\*If necessary, waivers are available in Allied Health Office

**Measles** Vaccination (date) \_\_\_\_\_ *if given after age 12 months need 2 doses 4-8 weeks apart*

**(Rubeola)** Titer Results     Positive     Negative    Read by (initial) \_\_\_\_\_

**Mumps** Vaccination (date) \_\_\_\_\_ *if given after age 12 months need 2 doses 4-8 weeks apart*

Titer Results     Positive     Negative    Read by (initial) \_\_\_\_\_

**Rubella** Vaccination (date) \_\_\_\_\_ *if given after age 12 months need 2 doses 4-8 weeks apart*

Titer Results     Positive     Negative    Read by (initial) \_\_\_\_\_

**Varicella** Vaccination (date) \_\_\_\_\_ *if given after age 12 months need 2 doses 4-8 weeks apart*

Titer Results     Positive     Negative    Read by (initial) \_\_\_\_\_

**Diphtheria/Tetanus (within 10 years)** Vaccination (date) \_\_\_\_\_

**Flu (seasonal)** Vaccination (date) \_\_\_\_\_

Physicians Signature \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_