*Falcon Institute of Health and Science*

Phone 610-253-2527
Fax 610-438-0201
www.falconihs.com

# PHYSICAL EXAMINATION FORM

This form is to be completed and signed by a Physician, PA, or CRNP.

Name: ___________________________________

| DOB | Age | Ht. | Wt. | T | P | R | BP |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

**Glasses/Lenses:** Yes No

**Hearing:** Normal Impaired Hearing Aid

| Physical Exam | Normal | Abnormal | Comments |
|---|---|---|---|
| General Appearance | | | |
| Skin | | | |
| HEENT | | | |
| Teeth | | | |
| Neck | | | |
| Lungs | | | |
| Heart | | | |
| Abdomen | | | |
| GU | | | |
| Musculoskeletal | | | |
| Back/Spine/Gait | | | |
| Neurological | | | |
| Mental Health | | | |

Fit for duty: Yes No

Restrictions: Yes No
For how long (dates) ___________________________

Comments:
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

Signature of Healthcare Examiner: ___________________________________

Print Name and Credentials: ___________________________________

Date of Signature: ___________________________________

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# TUBERCULOSIS FORM

Name: ________________________________________

Tests must be performed within 12 months of the start of the program. TB testing is done every year.

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**Option A PPD Skin Test**

| | Date Given | Date Read | Induration | Result | If positive, student must have IGRA. |
|---|---|---|---|---|---|
| Test 1 | | | | Pos Neg | |
| Test 2 | | | | Pos Neg | |

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**Option B Iterferon Gamma Release Assay (IGRA)**

| Date | Type | Results | If positive, student must have a chest x-ray. |
|---|---|---|---|
| | T-Spot<br>Quantiferon | Pos Neg | |

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**Option C Chest X-Ray**

| **Date** (Must be within the past calendar year) | **Results** | **Date Treatment Started** (if positive) | **Date Treatment Completed** (if positive) |
|---|---|---|---|
| | Pos Neg | | |

Signature of Healthcare Examiner: ________________________________________

Print Name and Credentials: ________________________________________

Date of Signature: ____________________________________________________

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## TETANUS-DIPHTHERIA-PERTUSSIS (TDAP) FORM

This form is to be completed and signed by a Physician, PA, or CRNP. Tdap (Adacel, Boostrix) lasts for 10 years.

Name: ____________________________________

Date given: ___________________ (must be within last 10 years)

Signature of Healthcare Examiner: ________________________________________

Print Name and Credentials: ______________________________________________

Date of Signature: ____________________________________________________

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## MMR (Measles, Mumps, Rubella) FORM

This form is to be completed and signed by a Physician, PA, or CRNP. The MMR vaccine lasts for 10 years. If no vaccine dates are available, please complete the titer. If titer is positive, no vaccination is required.

Name: ______________________________________

| Initial Vaccination | 28 Days After 1st Dose |
|---|---|
| Dose 1: | Dose 2: |

**OR Serologic Evidence of Immunity:**

| Titers | Value | Reference Range | Results | Date |
|---|---|---|---|---|
| Measles (Rubeola) | | | Pos Neg | |
| Mumps | | | Pos Neg | |
| Rubella (German Measles) | | | Pos Neg | |

Signature of Healthcare Examiner: ___________________________________________

Print Name and Credentials: _______________________________________________

Date of Signature: ________________________________________________________

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# VARICELLA (CHICKEN POX) FORM

This form is to be completed and signed by a Physician, PA, or CRNP.

Name: ______________________________________

History of Varicella: YES NO

If history of Varicella is present and titer is positive, vaccinations are not needed. The Varicella vaccine (Varivax) lasts for 10 years.

| **Vaccination dates a minimum of 4 weeks apart.** | |
|---|---|
| Dose 1 Date: | Dose 2 Date: |

**OR Serologic Evidence of Immunity:**

| Titer | Value | Reference Range | Results | Date |
|---|---|---|---|---|
| Varicella | | | Pos Neg | |

Signature of Healthcare Examiner: ___________________________________________

Print Name and Credentials: ______________________________________________

Date of Signature: _______________________________________________________

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# HEPATITIS FORM

This form is to be completed and signed by a Physician, PA, or CRNP.

Name: ______________________________________

| Initial Vaccination | One Month After 1st Dose | 6 Months After 1st Dose |
|---|---|---|
| Dose 1 date: | Dose 2 date: | Dose 3 date: |

**OR Serologic Evidence of Immunity:**

| Titer | Value | Reference Range | Results | Date |
|---|---|---|---|---|
| Hepatitis | | | Pos Neg | |

Signature of Healthcare Examiner: ________________________________________

Print Name and Credentials: ______________________________________________

Date of Signature: ______________________________________________________

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## FLU VACCINATION FORM

Name: ____________________________________

Allergies: ______________________

Flu Vaccine Date: _______________

Provider Signature: ______________