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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REFERENCE SHEET

- Hepatitis Titer or proof of 3 immunization (good for 20 years)
- Varicella (Chicken Pox) Titer or proof of 2 immunization (good for 10 years)
- Measles/Mumps/Rubella (MMR) Titer or proof of 2 immunizations (good for 10 years)
- TDAP (good for 10 years)
- PPD Skin Test (Tuberculosis) good for 1 year

TUBERCULOSIS FORM

Name: _____

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

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	

Option B Iterferon Gamma Release Assay (IGRA)

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

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: _____