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

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TUBERCULOSIS FORM

Name: _____

Option A PPD Skin Test
Tests must be performed within 12 months of the start of the program.

	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	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 ten (10) years. If vaccination date is greater than ten (10) years ago, vaccination must be given.

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. If no vaccine dates are available, please complete the titer. If titer is positive, no vaccination dates are 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. If no vaccine dates are available, please complete the titer. If history of Varicella is present **AND** titer is positive, vaccinations are not needed

Name: _____

History of Varicella: YES NO

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. If no vaccine dates are available, please complete the titer. If titer is positive, no vaccination dates are required.

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

This form is to be completed and signed by a Physician, PA, or CRNP. The flu vaccination is good for one (1) year. If vaccination date is greater than one (1) year ago, vaccination must be given. If exempt for allergy or religious reasons, documentation must be provided from healthcare provider.

Name: _____

Allergies: _____

Flu Vaccine Date: _____ (must be within last year)

Signature of Healthcare Examiner: _____

Print Name and Credentials: _____

Date of Signature: _____