Falcon Institute of Health and Science

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

PHYSICAL EXAMINATION FORM

Students accepted into the Practical Nurse Education Program must submit this form within 1 month of the start of the program to start the clinical rotations.

Deadline to submit the completed form: February 18th, 2022

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

Student 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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IMMUNIZATION RECORD FORM

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

Student Name: ________________________________ DOB: ____________________

All students are required to be up to date on the vaccinations listed on this form.

- Measles/Mumps/Rubella (MMR) Yes ____
- Varicella Yes ____
- Hepatitis B Yes ____
  If student is currently receiving series of Hepatitis B, they are considered up to date.
  Please provide the dates for the next doses ______________________________.
- Tetanus, Diphtheria & Pertussis (TDAP) Yes ____

The student is current with vaccinations named above.

Signature of Healthcare Examiner: ____

Print Name and Credentials: ____

Date of Signature: ____

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TUBERCULOSIS FORM

Student 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	Result Verified By:
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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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.

Student Name: ____________________________________

Allergies: __________________________________

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

Signature of Healthcare Examiner: ____

Print Name and Credentials: ____

Date of Signature: ____