

## PHYSICAL EXAMINATION REPORT

THIS FORM MUST BE COMPLETED AND SUBMITTED EVEN IF YOU HAVE OTHER DOCUMENTATION.

PATIENT NAME: \_\_\_\_\_ EXAM DATE: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: : \_\_\_\_\_

TEMP \_\_\_\_\_ PULSE \_\_\_\_\_ RESP. \_\_\_\_\_ B.P. \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

Has patient taken any depressants, narcotics, barbiturates, stimulants, alcohol or other drugs or substances which may alter behavior? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, which medication or drugs? \_\_\_\_\_

### IMMUNIZATION SUMMARY

Rubella (German Measles): Immunization Date: \_\_\_\_\_ Titer Results: \_\_\_\_\_

Rubeola (Measles): Immunization Date: \_\_\_\_\_ Titer Results: \_\_\_\_\_

Mumps: Immunization Date: \_\_\_\_\_ Titer Results: \_\_\_\_\_

Varicella Zoster (Chicken Pox): Immunization Date: \_\_\_\_\_ Titer Results: \_\_\_\_\_

Tetanus/Diphtheria: Date: \_\_\_\_\_

Hepatitis B: Yes \_\_\_\_\_ No \_\_\_\_\_ or Refused: \_\_\_\_\_

Date: \_\_\_\_\_ (see waiver)

Vaccination Date : #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

Tuberculin Test- PPD: Date Administered: \_\_\_\_\_ Date Read: \_\_\_\_\_

Results: NEGATIVE / POSITIVE \_\_\_\_\_ mm

Chest X-Ray(if positive): Date: \_\_\_\_\_ Results: NEGATIVE / POSITIVE

2nd Step(if needed): Date: \_\_\_\_\_

I CERTIFY THAT I HAVE EXAMINED THE ABOVE-NAMED INDIVIDUAL AND HAVE FOUND HIS/HER HEALTH TO BE SATISFACTORY TO WORK IN THE HEALTH CARE FIELD.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Physicians's Stamp: \_\_\_\_\_ License #: \_\_\_\_\_