In order to continue to participate in the clinical portion of any health science program, the student must complete a Medical History and Physical Examination Update form. Documentation, such as lab results must be attached to the form.

Be certain to take all documentation of immunizations with you to your physical examination so that the form can be completed correctly. Failure to submit the original form - complete with documentation - may prevent you from progressing to the clinical portion of your program.

To assist the student and the Health Care Examiner - MD, DO, nurse practitioner (ARNP) or physician assistant (PA) - in completing this form, instructions are provided below. **Students are responsible for the cost of the physical examination and any related expenses.**

---

**Section 1: Student Self-Report of Medical History**

**Student Statement**
This section must be reviewed and signed by the student. This section, wherein information about past and current health status is detailed, should be completed by the student **prior** to having a physical examination. **Be sure to include the name of the program on each of the pages of the form.**

**Section 2: Physical Examination**

**Laboratory Findings**

**Health Care Examiner’s Statement**
This section is to be completed by the Health Care Examiner (MD, DO, ARNP and PA only). Review of the program’s Technical Performance Standards is required. All sections must be completed with a signature provided.

The Health Care Examiner will review any documentation the student provides as related to tuberculosis.

**Tuberculosis**
- Documentation of PPD skin test results indicating negative reactivity reported within three months of the physical examination or
- Evidence of a chest x-ray within three months of the physical examination and medical treatment for those with positive reactivity or past history of positive reactivity.

Submit the completed form – pages 1 and 2 – with all required documentation submitted to the appropriate program representative.

Prior to submitting the form, please make copies for your own records.

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Information detailed on the Medical History and Physical Examination form is legally privileged and confidential. It is intended for use by the Health Science program unless written consent has been provided for release to other parties.
Section 1: Student Self-Report of Medical History

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Student ID #</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Emergency Contact Name</th>
<th>Relationship</th>
<th>Contact at:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Email Address</th>
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</table>

**Annual Update of Review of Systems / Medical History — please check all that apply**

- Abnormal Bleeding
- Hepatitis
- Allergies
- Hernia
- Anemia
- High Blood Pressure
- Anxiety
- High Cholesterol
- Arthritis
- Intestinal / Stomach Trouble
- Asthma
- Low Back Condition / Scoliosis
- Cancer of __________________
- Mononucleosis
- Chest Pain
- Neck Condition
- Chronic Cough
- Neurological Disorder
- Concussion / Head Injury
- Orthopedic Disorder
- Emotional Disturbance
- Prior Surgery
- Depression
- Rheumatic Fever
- Diabetes
- Seizure Disorder
- Ear Trouble / Hard of Hearing
- Sickle Cell Trait
- Eating Disorder
- Sinus Problems
- Eye Trouble / Vision Loss
- Skin Disease
- Fracture of __________________
- Splenectomy
- Gallbladder Disease
- Sprain of __________________
- Headaches / Migraines
- Syncope / Fainting
- Heart Murmur or Arrhythmia
- Thyroid Disease
- Heart Problems (other)
- Tuberculosis

Please indicate any health concerns, if any, that you presently have:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Student Statement**

The information provided on the Medical History and Physical Examination Update form is accurate to the best of my knowledge. I have attached required results of any laboratory test.

I am aware that the Medical History and Physical Examination Update form will be reviewed and will be returned to me if there are any incomplete sections or if additional documentation is requested.

I understand that failure to complete the form correctly may jeopardize my participation in the clinical portion of the program.

Student Signature:       Date:

---

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Section 2: Physical Examination

Examiner: Please examine this student as you would for a routine check-up. This student will be working closely with people in various health care settings.

HEIGHT: ________    WEIGHT: ________    BLOOD PRESSURE: ________    PULSE ________

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>NORMAL</th>
<th>FINDING</th>
<th>COMMENTS/PREVIOUS CONDITIONS/SURGERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
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<tr>
<td>Endocrine/Metabolic</td>
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<tr>
<td>Eyes/Ears/Nose/Throat</td>
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<td>Gastrointestinal</td>
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<td>Genitourinary</td>
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<td>Neurological</td>
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<tr>
<td>Respiratory</td>
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</tbody>
</table>

Is the student under treatment for any medical, surgical or emotional condition? YES  NO
If yes, please provide details:
___________________________________________________________________________________________________

Is the student now taking any medications? YES  NO
If yes, please list:
__________________________________________________________________________________________________

Does the student require any follow-up health supervision? YES  NO
If yes, please specify:
___________________________________________________________________________________________________

Mantoux PPD – Tuberculin Test – required annually

Test Date:                  | Attach results of laboratory test
If result of tuberculin test is positive, a chest X-ray is required.
Chest X-ray Date:           | Attach results

I have verified that the individual I have examined is the named individual on this form and that the above tests/vaccinations were performed in this office/laboratory.

Examiner’s Name (Please print)  ____________________________ Phone ____________________________
License # _______________ Signature of Health Care Examiner ____________________________ Date _______________

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