SPECTRUM NURSES Inc

PHYSICAL EXAM FORM

To be completed by student:

Name _____

Address _____
Street City State Zip

Phone # _____

E-mail address _____

Birthdate _____ Age _____

Person to notify in case of emergency:

Name _____

Phone# _____

Relationship _____

Primary Healthcare Provider _____

Phone# _____

Address _____

To Be Completed by M.D. or Advanced Healthcare Practitioner:

Immunizations:

Tdap: Date given:

Tuberculosis skin test: #1. Date given: _____ Signature: _____

Date read/reaction: _____ Signature: _____

(2-step Mantoux)

#2. Date given: _____ Signature: _____

Date read/reaction: _____ Signature: _____

The second Mantoux test must be administered within 7-21 days of the first test, if the reaction to the initial test is negative. Reaction at test site should be read within 48-72 hours. **TB Time is not acceptable.** If a student has a recorded positive Mantoux, a chest x-ray is required. ***Student may choose to have a Quantiferon Gold blood test in place of 2-step TB.***

Hepatitis B Vaccination (OPTIONAL) 1. _____ 2. _____ 3. _____

PHYSICIAN: In the section below, denote whether area is within normal limits (WNL) or abnormal. Record details in the remarks section.

WNL	ABNORMAL	
_____	_____	General Appearance
_____	_____	Eyes (Include lids, pupils, fundi, EOM)
_____	_____	Nose
_____	_____	Mouth
_____	_____	Throat (Include pharynx, tonsils)
_____	_____	Teeth and Gums
_____	_____	Neck (Include carotids and thyroid)
_____	_____	Lymph Nodes (cervical, axillary, inguinal, epitrochlear)
_____	_____	Chest and lungs
_____	_____	Heart (Size, rhythm, murmur, quality of tones, thrill)
_____	_____	Abdomen (appearance, liver, spleen, scars, mass, tenderness)
_____	_____	Hernia (umbilical, inguinal, femoral, incisional)
_____	_____	Extremities (Feet, edema, pulses, ROM, deformity)
_____	_____	Skin
_____	_____	Back (attention to list, pelvic, tilt, scoliosis, ROM)
_____	_____	Neurological (Include reflexes)

Explain any checks in the abnormal section. (Note asthma or diabetes)

Student is able to participate in all aspects of the course (clinical included) without restrictions.

Practitioner signature: _____ Date: _____

Practitioner name printed: _____

_____

Street Address City State Zip Code

Phone # _____

SPECTRUM NURSES TRAINING
481 W. BOUGHTON RD. #400
BOLINGBROOK, IL 60440

PHYSICIAN'S STATEMENT OF SATISFACTORY HEALTH

Name_____

Address_____

City_____State_____Zip_____

I hereby authorize my Physician to furnish Spectrum Nurses Training with the results of my physical and TB Results.

Signature_____Date_____

Dear Dr.

Please fill out this form stating that you have examined the above-mentions individual and have found him/her to be good health and free from communicable diseases.

Date of Physicals: _____

Date of TB Skin Test: _____

Physician's Signature:_____Date_____

Address: _____