Mail or fax completed form to:
Virginia Reynolds – College Health Records Office
Southwest Tech – Health Science Center
1800 Bronson Boulevard, Fennimore, WI 53809
Phone: 608-822-2648 FAX: 608-822-2776 Email: vreynolds@swtc.edu

HEALTH/PHYSICAL EXAMINATION FORM

STUDENT'S NAME: _____ **SEX:** _____ **BIRTH DATE:** _____

STREET: _____ **CITY:** _____ **STATE:** ___ **ZIP:** _____

PHONE: ( ) _____ **E-MAIL:** _____

PROGRAM START DATE: _____ **PREVIOSLY ENROLLED AT SWTC**_____

PROGRAM:

- ☐ ADN (Full-Time)
- ☐ ADN (Part-Time)
- ☐ Cancer Information Mngt
- ☐ Child Care/Early Childhood
- ☐ Dental Assistant
- ☐ EMT/AEMT
- ☐ Health Information Mngt
- ☐ Medical Assistant
- ☐ Medical Lab Tech
- ☐ Midwife
- ☐ Nursing Assistant
- ☐ Physical Therapist Asst

PHYSICAL FINDINGS

(To be completed by an MD/CNP or PA)

Height: _____ **Weight:** _____ **B/P:** _____ **P** _____ **R** _____

Basic Vision Screening: _____

Do abnormalities appear in the following systems?

Ears, eyes, nose, throat	☐ Yes ☐ No	Musculoskeletal	☐ Yes ☐ No
Gastrointestinal	☐ Yes ☐ No	Genitourinary	☐ Yes ☐ No
Cardiovascular	☐ Yes ☐ No	Metabolic	☐ Yes ☐ No
Respiratory	☐ Yes ☐ No	Neurological	☐ Yes ☐ No

If yes, please specify/explain: _____

_____

This individual is free from communicable diseases within the parameters of this assessment.

☐ Yes ☐ No

Special recommendations regarding the health or physical limitations of this student while participating in the program named at the top of this form:

For Child Care Program Students: I certify, based upon my examination that this person appears to be physically able to work with children. NOTE: This individual will be in contact with children receiving child care services and may be responsible for the physical care and social development of young children during the hours child care is provided. Some lifting of young children may be required.

Physician's Signature: _____

Print name: _____

Street: _____

City: _____ **State:** _____ **Zip** _____

Telephone: _____ **Date:** _____

IMMUNIZATION/COMMUNICABLE DISEASE AND ALLERGY HISTORY REQUIREMENTS

Student must submit a printed record of the following immunizations or blood testing to meet health requirements. Printed records or documented proof may be obtained from your primary care provider, public health office (if that is where you obtained your immunizations), or the Wisconsin Immunization Registry website at https://www.dhfswir.org

Hepatitis B: *Need **printed record** for documented proof of **3** vaccine dates **OR** copy of blood test indicating immunity to Hepatitis B.*

MMR: **-** *Need **printed record** for documented proof of **2** vaccine dates OR a copy of blood test indicating immunity to MMR*

Varicella (Chicken Pox): *Need **printed record** for documented proof of **2** vaccine dates OR **copy** of blood test indicating immunity to varicella.*

Influenza: *Need printed record for documented proof of 1 vaccine date during the flu season.*

Note: Please be aware that it could take up to 2 weeks to receive blood titer/test results.

ALLERGIES - *Circle if applicable*: **Latex** **Hay fever** **Asthma** **Eczema**

Foods (circle any food allergies): **Bananas** **Dairy** **Horse Serum** **Avocado** **Kiwi** **Tomato**

Other Allergies: _____

TOBACCO PRODUCTS: If you use, list type, frequency, and duration of use: _____

_____

I understand the information stated on this form and have completed the immunization/allergy history truthfully and accurately. I hereby give permission to release information from this form to Southwest Tech and clinical affiliates.

STUDENT SIGNATURE _____ **DATE** _____

Revised 03/20/2019