

ASHTABULA COUNTY TECHNICAL & CAREER CAMPUS

PRE-ENTRANCE PHYSICAL EXAMINATION

Name: _____ DOB ____/____/____ Gender: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Resp. _____

Health Questionnaire: (To be completed by the applicant)

1. Do you have any physical limitations which would affect your ability to lift, turn, or transfer patients? ____ Yes ____ No
2. Do you have any limitations in use of your sense, such as sight or hearing, which would limit your ability to practice a health profession? ____ Yes ____ No
3. Do you have any other condition which might interfere with your ability to practice in the health profession? ____ Yes ____ No

If you have answered "yes" to any of the above, please explain your limitations in detail: _____

List any medications you have taken on a regular basis in the last year:

HISTORY: Include any significant information regarding previous medical and surgical conditions, and use of alcohol and/or drugs:

Physical Examination

	Physical Findings	Abnormal	Describe abnormality:
	Eyes, Ears, Nose, Throat		
	Mouth, Teeth		
	Neck, Thyroid		
	Heart, Vascular		
	Lungs		
	Neurological		
	Abdomen, hernia		
	Extremities Deformity, varicose veins		
	Skeletal: curvature, back, vertebrae, disc		
	Skin, scars, hernias		

Laboratory Findings: (Please indicate date received)

Tuberculin Test within 1 Year (Double Mantoux):

Date _____

Date _____

Results: _____

Results: _____

Chest X-ray: (if applicable): _____

Immunity to the following through a documented Titer (Blood Test)

Copies of blood tests (titers) must be attached to this physical form. If titers are low, immunization will be required.

Measles (Rubeola) _____

Varicella (Chicken Pox) _____

German Measles (Rubella) _____

Hepatitis B _____

Mumps: _____

Tdap _____

10 Panel Drug Screen: Copy of results must accompany this physical form. Results must be in a sealed envelope from the facility.

HEALTH CARE PRACTITIONER RECOMMENDATION

Based upon your physical examination, is the applicant free of any restrictions in his/her ability to turn and/or move heavy objects? If "no," please describe: Yes ____ No ____

Is the applicant able to see and hear adequately to practice a health care profession? Yes ____ No ____
If "no," please explain:

Is the applicant free of any pathological conditions either physical or mental that would interfere with the practice of a health profession? Yes ____ No ____
If "no," please describe:

Signature of Physician or Nurse Practitioner _____ Date _____

Printed Name of Physician or Nurse Practitioner _____

Address of
Physician/Practitioner _____

**Please return to: A-Tech RN Program
 1565 State Route 167
 Jefferson, OH 44047**

NOTE: Upon receipt of this form, we will review it for completeness. It is the student's responsibility to make sure physical form is complete and returned before the first day of school. If incomplete, the form will be returned. Students will not be allowed to begin clinical rotations if physical form is incomplete and will be marked absent for time missed.