HCI COLLEGE

# MEDICAL EXAMINATION FORM

(INFORMATION CONTAINED HEREIN WILL BE HELD IN CONFIDENCE)

Full Name: _____ Exam Date: _____
Last 4 of SSN: _____ Date of Birth: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: _____ Cell #: _____

**All the following information must be provided and/or completed by a health care provider (MD, DO, ARNP, or PA)**

**Medical History:**
Allergies: _____
Current Medications: _____
Surgeries: _____
Major Illnesses: _____
Back/Orthopedic Problems: _____

History of any communicable or infectious disease(s) which may prevent or hinder this applicant's ability to become a member of the healthcare profession. **[ ]NO [ ]YES** (if yes, please explain)
_____
_____
_____

**Physical Examination**:

| Height | Weight | Pulse | Blood Pressure |
|---|---|---|---|
| | | | |

| Vision | Hearing |
|---|---|
| | |

**Positive Findings:** _____
_____
_____
_____

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**PATIENT NAME**: _____**DOB: _____**

*SHOT RECORDS ARE NOT A SUBSTITUTE FOR TITERS
*NO PHYSICALS OR RECORDS OVER **ONE YEAR** OLD WILL BE ACCEPTED
*TITERS MUST DEMONSTATE IMMUNITY, IF NOT VACCINATIONS/BOOSTERS ARE REQUIRED

| **Diagnostic Tests/Flu** | **Results Date** | **CHECK ONE** | |
|---|---|---|---|
| | | **Immune** | **Not Immune** |
| Hepatitis B Titer | | | |
| Rubella Titer | | | |
| Rubeola Titer | | | |
| Varicella Titer | | | |
| PPD | | (negative) | (positive) |
| Flu Shot (only needed from Sept-Mar) | | | |

**(Below are only needed if student does not show immunity to above)**

| **Immunizations** | **Date** |
|---|---|
| Rubella vaccine | |
| Rubeola vaccine | |
| Varicella vaccine | |
| Tdap (only needed if over 10 years) | |
| *Hepatitis B vaccine<br>*(Hep B vaccine only needed if not immune and has completed series) | |
| **Chest X-Ray<br>**(Chest X-Ray is required as a follow-up for positive PPD results. After chest X-Ray has been completed) | |

Hepatitis B Series: #1_____ (date) #2_____ (date) #3_____ (date)
(Hep B series only needed if individual has not started the series or is currently in the series)

Additional Comments/Recommendations:_____
_____

**To the best of my knowledge, this individual is in good physical and mental health.**
**[ ]NO [ ]YES** Date: _____

_____/ _____
Signature of Health Care Examiner Name of Health Care Examiner

_____
Address City/State/Zip Telephone #

American Heart Association. | AUTHORIZED TRAINING CENTER

Classes held on campus

**Register online WWW.HCI.EDU**
**or call (561) 586-0121**

$50.00 for the REQUIRED BLS COURSE