



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: _____
 SOCIAL SECURITY NUMBER: _____ DATE STARTING PROGRAM: _____
 If previously enrolled at SWTC, program attended: _____ Year _____

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

Date of Physical Exam must be no more than 2 years prior to the beginning the clinical experience. Form is to be turned into the College Health Records Office. **NO student** will be permitted to start clinical until this form and the TB Skin Testing Form have been submitted and approved.

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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Musculoskeletal | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gastrointestinal | <input type="checkbox"/> Yes <input type="checkbox"/> No | Genitourinary | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiovascular | <input type="checkbox"/> Yes <input type="checkbox"/> No | Metabolic | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Respiratory | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological | <input type="checkbox"/> Yes <input type="checkbox"/> 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.dhfs.wisconsin.gov/immunization>

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

MMR: Measles (Rubeola) - Need printed record for documented proof of 2 vaccine dates OR a copy of blood test indicating immunity to rubeola.

Mumps – need printed record for documented proof of 2 vaccine dates OR a copy of blood test indicating immunity to mumps.

Rubella – need printed record for documented proof of 1 rubella vaccine date OR a copy of a blood test indicating immunity to rubella.

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.

**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 _____