Health Physical Form

Ohio Law prohibits discrimination on the basis of handicap, unless handicap creates a significant occupational hazard or prevents performance of essential job functions.

Part I. Student must complete prior to seeing PCP (please print)

Name: ____
Last First Middle Initial

Address: ____

City: ______________________ State: __________ Zip Code: ____________________

Cell: ___________________________ Home Phone: ___________________________

Emergency Contact: ___________________________ Phone: ______________________

Have you had any of the following health problems?

	No	*Yes (describe, please print)*
Diabetes		
Seizures		
Heart		
Lung		
Kidney		
Skin		
Liver		
Hepatitis: A, C or B		
Drug or Alcohol Treatment		

HIV/AIDS		
Hearing		
Vision problem not corrected by glasses or contacts		
Back pain or surgery		
Depression, anxiety, metal health problems		
Difficulty walking		
Other significant health issues		

I authorize any of the doctors, hospitals or clinics mentioned to furnish the Christ College of Nursing and Health Sciences complete transcripts of my medical record, if needed. I testify that the information on this form is correct to the best of my knowledge. I understand that falsification and/or withholding of any information pertinent to this questionnaire is grounds for automatic dismissal from the college.

Student Signature: ____ Date: ________________________________

Part II. PCP Complete

Sex	*Age*	*Height*	*Weight*	*BP*	*Pulse*
Vision WNL			*Allergies*		

	Normal	*Abnormal*	*Details of abnormality*
Head, neck, face, scalp			
Nose and sinuses			
Mouth, teeth, gums			

ENT			
Lungs			
Skin			
Heart/vascular system			
Abdomen			
Endocrine			
Upper extremities			
Lower extremities			
Spine/musculoskeletal			
Neurological			
Psychiatric			
Other			

Special Instructions regarding health status:

Yes	*No*	*Explain*

Part III. PCP complete immunization history

The following immunizations are REQUIRED for all students. There are NO exceptions to these requirements. Please have each line checked to verify that these are completed prior to submitting.

Annual PPD Test

Date Given: ___________________ Date Read: ___________________ Result: ______________________________

Two MMR's

Date Given: ___________________ Date Read: ___________________ Result: ______________________________

Hepatitis B vaccine (a series of 3 shots)

Date Given: ___________________ Date Given: ___________________ Date Given: ___________________

Titer: ___________________ (10 IU or greater)

TDAP (Tetanus, diphtheria and pertussis)

Booster after the age of 12 years must include pertussis and be within last ten (10) years. Documentation of booster must be provided if over ten (10 years). Documentation only, titers cannot be drawn for TDAP.

Date Given: ___________________

Proof of immunity to varicella (chicken pox) with one of the following:

1. Doctor statement of having history of chicken pox
2. Two varicella vaccines
3. A positive varicella titer

Instead of vaccines, if documentation is not available, titers can be drawn to prove immunity.

Provide a copy of the lab value to show immunity.

1. Positive measles titer: ___________________ (value over 1.10)
2. Positive mumps titer: ___________________ (value over 1.10)
3. Positive rubella titer: ___________________ (value over 1.10)
4. Positive varicella titer: ___________________ (value over 1.10)
5. Positive Hepatitis B titer: ___________________ (surface antibody at 10 IU or greater)

PCP signature (required): ____

Return completed form via email to immunizations@thechristcollege.edu.