COLUMBIA STATE COMMUNITY COLLEGE

EST. 1966

Physical Exam Form for
Radiologic Technology Students

www.columbiastate.edu
Phone: (931) 540-2849

Date of Exam:_____ **NOTE: Attach all Lab and Radiology reports to this form.**

Name of Student:_____ Sex: _____

Age:_____ Student Date of Birth: _____

Height:_____ Weight:_____ BP:_____ Pulse:_____ Temperature: _____

Urinalysis: Protein_____ Leukocytes_____ Glucose_____ Blood_____ Bilirubin _____

Hematocrit:_____ CBC (optional) _____

Eyes:_____ Visual Acuity R_____ L _____

Color Blindness: Y_____ N _____

Ears:_____ Hearing: R_____ L_____

Nose:_____ Oropharynx: _____

General condition of teeth (caries, dentures, braces, implants): _____

Skin:_____ Breasts: _____

Musculo-skeletal system (joint instability, inflammatory conditions, surgical repairs):_____ Spine: _____

Cardiovascular:_____ Respiratory: _____

Abdomen (pain, scars, masses, hernia): _____

Genito-urinary system:_____ Hemorrhoids:_____ Varicosities: _____

Is this student in good physical condition? Yes_____ No _____

Reasons he/she is not: _____

_____

_____

Physician's recommendations for further testing or comments: _

_____

_____

CoSCC AH-22-08-10

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Name of Student: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Student Home Phone Number: _____ Cell: _____

Date of 2-step T.B. skin test ***(required):*** 1st TB Date Administered: _____ Date Read: _____ Result: _____
2nd TB Date Administered: _____ Date Read: _____ Result: _____
TB skin test must be completed within 12 months prior to the start of clinical then annually throughout the program.

NOTE: If T.B. skin test is **positive**; you must submit a chest X-ray report. Date: _____ Results: _____
(Attach Radiologist's report)

Date of Mumps Titer/IGG ***(required):*** _____ **Attach lab report for result:** _____

Date of Rubella Titer/IGG ***(required):*** _____ **Attach lab report for result:** _____

Date of Rubeola Titer/IGG ***(required):*** _____ **Attach lab report for result:** _____

NOTE: If no immunity, MMR immunization is required. Date of MMR #1 _____ #2 _____

MMR Booster: _____
You must repeat titer(s) two months (60 days) following immunization. **Attach lab report for result.**

Date of Varicella Zoster titer/IGG ***(required)*** _____ **Attach lab report for result:** _____

If NOT immune: Date of Varicella Zoster immunization #1: _____ #2: _____
NOTE: You must repeat titer(s) two months (60 days) following immunizations. **Attach lab report for result.**

Have you had chicken pox? YES _____ NO/NOT SURE _____

Date of Influenza Vaccine (seasonal August-April) (Required for Radiologic students): _____

Date of Tdap (Tetanus, Diphtheria and Pertussis) _____ ***You must have a booster if you vaccination is over 10 years old***

Date of Hepatitis B series (received): #1 _____ #2 _____ #3 _____

Date of Hepatitis B titer **(Attach Hepatitis B titer lab report).** Results: _____
Hepatitis B vaccine series is mandatory, but the student will be required to sign a waiver if he/she decides not to receive it due to religious reasons or a prior allergic reaction (Both must be verifiable).

_____, M.D./N.P.
Physician's or Nurse Practitioner's Signature

_____
Physician's Address

_____, M.D./N.P.
Print or type Physician's or Nurse Practitioner's Name

_____
Date of Examination

Revised 06/16