Form C
UNIVERSITY OF CENTRAL MISSOURI
University Health Center
Physical Exam

Applicant: ___________________________________ Date of Birth: ______________
(Last) *(First)* *(M.I.)*

Address: ____
(Street)

____ ______________________
(City) *(State)* *(Zip Code)* *(Phone)*

Student ID #: ___________________________

Immunizations

Immunization	Date	Date	Date	Date
Polio				
Diphtheria-Tetanus		XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX
MMR			XXXXXXXXXX	XXXXXXXXXX
Hepatitis B				XXXXXXXXXX

Tuberculin test *(complete all that apply)*

TB skin test within the past year Date: Type: Reaction:	Chest X-ray for positive PPD Date: Result:	Completed treatment regimen for active or latent TB Date Completed: Medication:

Varicella (*complete one of the following)*

Age at time of disease Date:	Varicella titer Date: Results:	Varicella Vaccine Date :

Health History:

Allergies:____

Current
Medications:____

Significant medical illness/injury, hospitalization, surgery:

____

____

____

History of mental illness, treatment, or therapy:__________________________________

____

Physical Examination:

T: ________ P: _________ R: _________ B/P:_______________

Height: __________ Weight: __________

Skin: ____

Eyes: _____________________________Vision: OD _________ OS_________

Glasses/Contacts: ____

Ears: _______________________________ Neck: ______________________________

Nose: ______________________________ Throat: ____________________________

Lungs: __________________________ Heart: _________________________________

Abdomen: ____

Musculoskeletal: ____

Recommendations: *(please check one)*

_______ Applicant is free of any limitations in health that would impede provision of health care to others.

_______ Applicant's ability to provide health care to others is limited by the following:

____
(MD/DO/PAC/ARNP printed name)

____
(MD/DO/PAC/ARNP signed name)

____
(Date)