Appendix C
UNIVERSITY OF CENTRAL MISSOURI
University Health Center
Physical Exam

Applicant: _____ Date of Birth: _____
(Last) (First) (M.I.)

Address:_____
(Street)

Address: _____ _____
(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:

_____
(Healthcare Provider's printed name)

_____
(Healthcare Provider's signed name)

_____
(Date)