# WILCO AREA CAREER CENTER

**500 Wilco Blvd.**
**Romeoville, IL 60446**

# PHYSICAL EXAM FORM

## To be completed by student:

Name_____ Home School_____

Address_____
Street City State Zip

Phone #_____

E-mail address _____

Birthdate_____ Age_____

## Person to notify in case of emergency:

Name_____

Phone#_____

Relationship_____

Family Physician_____

Phone_____

Address_____

# To be completed by physician:

## Immunizations:

**Tuberculosis skin test**:#1.Date given:_____Date read/reaction: _____
(2-step Mantoux)
#2.Date given:_____Date read/reaction: _____
**TB Tine test is not acceptable.**

Documentation of a 2 Step TB Mantoux test is required prior to the start of clinicals. The second Mantoux test must be administered within 7-21 days of the first test, if the reaction to the initial test is negative. A single step Mantoux is adequate if a 2 step Mantoux was done within the past year. **TB Tine is not acceptable.** If a student has a recorded positive Mantoux, a chest x-ray is required.

*Reaction at test site should be read within 48-72 hours.

PHYSICIAN: In the section below, denote whether area is within normal limits (WNL) or abnormal. Record details in the remarks section.

| WNL | ABNORMAL | |
|---|---|---|
| _____ | _____ | General Appearance |
| _____ | _____ | Eyes (Include lids, pupils, fundi, EOM) |
| _____ | _____ | Nose |
| _____ | _____ | Mouth |
| _____ | _____ | Throat (Include pharynx, tonsils) |
| _____ | _____ | Teeth and Gums |
| _____ | _____ | Neck (Include carotids and thyroid) |
| _____ | _____ | Lymph Nodes (cervical axillary, inguinal, epitrochlear) |
| _____ | _____ | Chest and lungs |
| _____ | _____ | Heart (Size, rhythm, murmur, quality of tones, thrill) |
| _____ | _____ | Abdomen (appearance, liver, spleen, scars, mass, tenderness) |
| _____ | _____ | Hernia (umbilical, inguinal, femoral, incisional) |
| _____ | _____ | Extremities (Feet, edema, pulses, ROM, deformity) |
| _____ | _____ | Skin |
| _____ | _____ | Rectal |
| _____ | _____ | Pelvic |
| _____ | _____ | Back (attention to list, pelvic, tilt, scoliosis, ROM) |
| _____ | _____ | Neurological (Include reflexes) |

Explain any checks in the abnormal section. (Note asthma or diabetes)

**Student is able to participate in all aspects of the course (clinical included) without restrictions.**

Physician signature:_____ Date:_____

**Physician name printed:**_____

_____

Street Address City State Zip Code

Phone #_____

OFFICE USE:

DATE RECEIVED_____