ASHTABULA COUNTY TECHNICAL & CAREER CAMPUS

PRE-ENTRANCE PHYSICAL EXAMINATION

Name: _____ DOB _____/_____/_____ Gender: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Resp._____

Health Questionnaire: (To be completed by the applicant)

1. Do you have any physical limitations which would affect your ability to lift, turn, or transfer patients? ____ Yes ____ No
2. Do you have any limitations in use of your sense, such as sight or hearing, which would limit your ability to practice a health profession? ____ Yes ____ No
3. Do you have any other condition which might interfere with your ability to practice in the health profession? ____Yes ____No

*If you have answered "yes" to any of the above, please explain your limitations in detail:*_____

_____

_____

_____

List any medications you have taken on a regular basis in the last year:

_____ _____

_____ _____

_____ _____

HISTORY: Include any significant information regarding previous medical and surgical conditions, and use of alcohol and/or drugs:

_____

_____

_____

_____

_____

Physical Examination

	Physical Findings	Abnormal	Describe abnormality:
	Eyes, Ears, Nose, Throat		
	Mouth, Teeth		
	Neck, Thyroid		
	Heart, Vascular		
	Lungs		
	Neurological		
	Abdomen, hernia		
	Extremities Deformity, varicose veins		
	Skeletal: curvature, back, vertebrae, disc		
	Skin, scars, hernias		

Laboratory Findings: (Please indicate date received)

Tuberculin Test within 1 Year (Double Mantoux or bloodwork):

Date _____ Date_____

Results: _____ Results: _____

Chest X-ray: (if applicable):_____

Immunity to the following through a documented Titer (Blood Test) for all. Copies of blood tests (titers) must be attached to this physical form. If titers are low, immunization will be required.

Measles (Rubeola) _____ Varicella (Chicken Pox) _____
German Measles (Rubella) _____ Hepatitis B _____
Mumps: _____

Immunizations
Tdap (within 10 yrs) _____
COVID (up to date according to CDC or clinical agency)_____

10 Panel Drug Screen: Copy of results must accompany this physical form. Results must be in a sealed envelope from the facility.

HEALTH CARE PRACTIONER RECOMMENDATION

Based upon your physical examination, is the applicant free of any restrictions in his/her ability to turn and/or move heavy objects? If "no," please describe: Yes ____ No ___

Is the applicant able to see and hear adequately to practice a health care profession? Yes ____ No____
If "no," please explain:

Is the applicant free of any pathological conditions either physical or mental that would interfere with the practice of a health profession? Yes ____ No____
If "no," please describe:

_____
_____
_____

Signature of Physician or Nurse Practitioner _____Date _____

Printed Name of Physician or Nurse Practitioner _____

Address of
Physican/Practitioner_____

Please return to: **A-Tech RN Program**

1565 State Route 167
Jefferson, OH 44047

NOTE: **Upon receipt of this form, we will review it for completeness. It is the student's responsibility to make sure physical form is complete and**

returned before the first day of school. If incomplete, the form will be returned. Students will not be allowed to begin clinical rotations if physical form is incomplete and will be marked absent for time missed.