Auburn Career Center

AUBURN PRACTICAL NURSING PROGRAM
PHYSICAL EXAMINATION RECORD (CONFIDENTIAL)

DATE: _______________

LAST NAME FIRST MIDDLE D.O.B. SEX MARITAL STATUS

STREET ADDRESS CITY STATEZIP PHONE NO.

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REQUIRED BY CLINICAL LEARNING SITES

All immunizations are current for candidate – exclusion may include those with life threatening allergies, pregnant and/or immune suppressed with documentation.

QuantiFERON Blood Test	________ (date)	________ (result)
Hepatitis B Vaccination Positive titer (date and results) OR Documentation of the Hep B 3-shot series OR Waiver signed and returned to the school.	________ (date)	________ (result)
Mumps Immunity Positive titer (date and results)	________ (date)	________ (result)
Rubella (German Measles) Positive titer (date and results)	________ (date)	________ (result)
Rubeola (regular measles) Positive titer (date and results)	________ (date)	________ (result)
DT Toxoid or Tdap Booster Within the last 10 years	________ (date)	
Varicella (chicken pox) Positive titer (date and results)	________ (date)	________ (result)
Non-DOT 10 panel pre-placement drug screen Needs to match the Ohio BWC Drug Free Safety Program cut off levels	________ (date)	Results sent to Auburn Practical Nursing Program 8140 Auburn Road, Concord Twp., OH 44077 -or- khowell@auburncc.org

****Students will be required to obtain proof of Flu Vaccination by the start of Flu Season as announced in September****

***** It is highly recommended that you have the COVID Immunization. Most healthcare facilities will require proof to participate in clinicals/employment. *****

Mark Appropriate Space:

	YES	NO		YES	NO		YES	NO
Allergies	___	___	GI disturbances	___	___	Nervousness	___	___
Asthma	___	___	Heart disease	___	___	Seizure disorder	___	___
Backaches	___	___	High blood pressure	___	___	Shortness of breath	___	___
Chronic cough	___	___	Infected sinuses	___	___	Swollen/painful joints	___	___
Frequent sore throats/colds	___	___	Kidney infections/stones	___	___	Varicose veins	___	___
Frequent headaches	___	___	Liver disease	___	___	Venereal disease	___	___

Health History, Medical Problems, Previous Operations_____

_____

_____

_____

Previous Serious Illness_____

HEIGHT _____ WEIGHT _____ TEMPERATURE _____ PULSE_____RESPIRATION_____ BLOOD PRESSURE_____

NORMAL	ABNORMAL	EXPLANATION OF FINDINGS
		ABDOMEN
		E N T
		EXTREMITIES
		EYES
		HEART
		LUNGS
		MUSCULO-SKELETAL
		PERIPHERAL VASCULAR
		SKIN
		SPINE (CURVATURE)
		THYROID

Currently receiving therapy or medications Yes____ No____ specify_____

_____

Has person been treated for any nervous disorder or emotional stress?
Yes _____ No _____ Current treatment/medication_____

_____

This individual's health status qualifies them to work directly with patients. Yes_____ No_____

_____

Physician Signature Physician's Printed Name Phone No. Date

I certify that the information on this record is accurate and complete. I understand if I offer false, misleading or incomplete information, I may be subject to dismissal from the Auburn Practical Nursing Program. **Additionally, you have my permission to call/contact the evaluating physician/organization regarding the accuracy and completeness of this physical examination record and submit same to clinical partners.**

Please make copies of all health records for your own file before submission to the school as no copies will be made for you at a later date.

_____

Applicant Signature Date