HEALTH SERVICES
Oakton Community College

Room 1210, 1600 East Golf Road, Des Plaines, IL, 847-635-1885, Fax 847-376-7010
Room A175, 7701 North Lincoln Avenue, Skokie, IL, 847-635-1419, Fax 847-376-7650

Health Career Physical Examination Report

Program _____

Name _____ Date of Birth _____ Phone number _____

Address _____ City _____ State ____ Zip _____

OFFICE USE ONLY

PHYSICAL FINDINGS – ***To be completed by a licensed health care provider***

Physical Examination

Ht. _____ Wt. _____ B/P _____ Pulse _____ Vision L _____ R _____

Corrective Lenses ❑ Yes ❑ No

Medical history _____ Allergies _____

Surgical history _____ Family history _____

Medications _____ Social history _____

Are there any abnormalities in the following areas?

	NO	YES	If yes, please describe.		NO	YES	If yes, please describe.
Cardiovascular	❑	❑	_____	Musculo-Skeletal	❑	❑	_____
Eye	❑	❑	_____	Neurological	❑	❑	_____
Ear/Nose/Throat	❑	❑	_____	Respiratory	❑	❑	_____
Abdominal	❑	❑	_____	Skin	❑	❑	_____
Hearing	❑	❑	_____	Lymph Nodes	❑	❑	_____

Health risk issues addressed (smoking, drinking, drug use, safer sex) _____

_____

Summary of findings/comments _____

_____

❑ Student is medically cleared for the Health Career program without limitations.

❑ Student is **not** medically cleared for the Health Career program.

Health care provider signature _____ **Date** _____

Address _____

City State/Zip

Phone number _____

Office Stamp

— *over* —

Program _____

Name _____ Date of Birth _____

All individuals enrolled in a Health Career program must comply with the following program requirements:

Tuberculosis (TB)

PPD skin test annually; **if positive, a Quantiferon Gold blood test is required and must be attached.**

Skin Test: Date given _____ Date read _____ Result _____ mm

Vaccine MFG and Lot # _____ Exp. date _____

Administered by _____

2-step: Date given _____ Date read _____ Result _____ mm

Vaccine MFG and Lot # _____ Exp. date _____

Administered by _____

Chest x-ray: Date _____ Result ❑ Positive ❑ Negative

Hepatitis B

Has the student had the Hepatitis B vaccine series? ❑ No ❑ Yes

If Yes, please provide documentation of dates 1. _____ 2. _____ 3. _____

Tdap

Date of Tdap vaccine: _____

NO student will be allowed to attend clinical classes until health forms are completed and returned to Health Services.
