SANTA BARBARA CITY COLLEGE

Health Technologies Programs Physical Exam Form

Student Name _____

Student K#_____

Height_____ Weight_____

To be completed by primary health care provider

Vital signs: Temp Pulse Resp

Blood pressure

NORMAL	ABNORMAL	CHECK EACH ITEM IN APPROPRIATE COLUMN	DESCRIPTION OF ANY ABNORMALITIES
		Eyes	
		Ears – (Tympani, Canals, Discharge)	
		Nose	
		Mouth (teeth)	
		Throat (tonsils)	
		Neck	
		Chest (include breasts)	
		Lungs	
		Heart	
		Abdomen	
		Extremities	
		Varicose Veins	
		Feet (arches)	
		Spine (alignment, R.O.M.)	
		Neurologic	
		Skin/Scars	
		Rectal/Vaginal if indicated by history	
R_____L_____	R_____L_____	Hearing	
YES	NO	Is Hernia present?	
YES	NO	Does applicant appear healthy & alert?	

IMMUNIZATIONS MAY BE DOCUMENTED HERE WITH PHYSICIAN SIGNATURE *OR* AN OFFICIAL VACCINATION RECORD MAY BE UPLOADED SEPARATELY.

Required	**TB Skin Test** (must have been done within 12 months of beginning program) **Date Read:**		**Date given:**	Signature:
			Results:	Signature:
	If TB skin test is positive, QuantiFERON blood test is required			
	MMR (Measles, Mumps, Rubella Vaccination	#1	**Date:**	Signature:
		#2	**Date:**	Signature:
	Varicella Vaccination	#1	**Date:**	Signature:
		#2	**Date:**	Signature:
	T dap Vaccination (pertussis)		**Date:**	Signature:
	Hepatitis B Immunization **Dates**: **1.** **2.** **3.**			Signature:
	**** ALL TITER BLOOD TESTS MUST BE UPLOADED SEPARATELY WITH OFFICIAL LAB REPORTS****			

1. Do you believe that this individual is and will likely be mentally and physically capable of pursuing a Health Technology program? Yes_____ No_____

If No, please explain_____

_____

2. Does he/she have any health related condition that would create a hazard to him/herself, fellow employees, patients, or visitors? Yes_____No_____

If Yes, please explain_____

_____

Signature _____**M.D. Date**_____

PHYSICIAN'S STAMP & ADDRESS

SANTA BARBARA CITY COLLEGE
Health Technologies Physical Exam Form

Student Name _____

To be completed by the student

A. Diseases or conditions you have had or have now: (give approximate dates)

Abnormal Back X-ray_____
Abnormal Bleeding_____
Abnormal Chest X-ray_____
Abnormal EKG_____
Alcoholism_____
*Allergies_____(list below)_____
Anemia_____
Arthritis_____
Asthma_____
Back Problems_____
Back Strain_____
Blurred Vision_____
Breathing Problems_____
Bronchitis_____
Cancer_____
Colds (frequent)_____
Constipation_____
Convulsions_____
Deformity_____
Diabetes_____
Dizzy Spells_____
Ear Aches_____
Emotional Illness_____
Epilepsy_____
Excessive Fatigue_____
Eye Problems_____
Fainting Spells_____
Frequent Cough_____
Frequent Headaches_____
Frequent Urination_____
Gallbladder_____
Gastric Ulcer_____
GI Bleeding_____
Hearing Problems_____
Heart Disease_____
Hepatitis_____
Hernia_____
High Blood Pressure_____
Jaundice_____
Joint Problems_____
Kidney Disease_____
Knee Problems_____
Liver Problems_____
Loss of Appetite_____
Menstrual Difficulties_____
Migraine_____
Mononucleosis_____
Neck Problems_____
Nervousness_____
Pain/Swollen Testicles_____
Palpitations_____
Polio_____
Rheumatic Fever_____
Skin Disease/Itching_____
Thyroid Disease_____
Tuberculosis_____
Varicose Veins_____

Sensitivity / Allergy to LATEX Yes_____No____ If yes, describe: _____

*Allergies: _____

Remarks: _____

B. List:
1. Any serious illness you have had – and date(s) _____
2. Any surgeries you have had – and date(s) _____
3. Any injuries you have had – and date(s) _____
4. Do you smoke?_____How much? _____
5. Do you drink alcohol?_____How much / often? _____

C. Are you under a doctor's care now?_____Name of Doctor _____
Reason for care _____

D. List medications taken regularly _____

I HEREBY CERTIFY THE FOREGOING RESPONSES TO BE TRUE:

DATE:_____SIGNATURE OF APPLICANT _____

Please submit completed form to: SBCC, EMT Representative 721 Cliff Drive, Santa Barbara, CA 93109-2394