EL CAMINO COLLEGE
Health Sciences and Athletics Division
Respiratory Care Program

Physical Exam Portion of RC application

PHYSICAL EXAMINATION FORM

HEALTH HISTORY PROFILE

NAME:_____ **PROGRAM:** _____ **DATE:**_____

ADDRESS:_____ **PHONE:**_____ **AGE:**___ **DOB:**_____

Instructions to Applicant: Complete the HEALTH HISTORY PROFILE (Page 1). Schedule an appointment with your health provider or El Camino College's Health Center for a physical examination, required laboratory tests and immunization update. Take this form to your scheduled appointment and have Page 2 completed by your health provider.

Please Note: Page 2 must be completed by an authorized health professional. Page 2 must be completed in its entirety before **submitting** this form **to** the **ECC Respiratory Care Program.**

Do you have or have you ever been treated for any of the following (explain all yes answers):

	YES	NO
1. Hearing problems	____	____
2. Wear glasses (Contacts)	____	____
3. Dental problems	____	____
4. False teeth (Bridges)	____	____
5. High blood pressure	____	____
6. Heart murmur	____	____
7. Ulcer	____	____
8. Nervous stomach	____	____
9. Gall bladder disease	____	____
10. Hemorrhoids	____	____
11. Hernia	____	____
12. Kidney/bladder infection	____	____
13. Kidney stones	____	____
14. Mononucleosis	____	____
15. Frequent sore throat	____	____
16. Appendicitis	____	____
17. Diabetes5____	____	
18. Hepatitis	____	____
19. Epilepsy	____	____
20. Frequent respiratory infection	____	____
21. Asthma	____	____
22. Anemia	____	____
23. Tuberculous	____	____
24. Tumors	____	____
25. Skin Problems	____	____
26. Cancer	____	____
27. Psychological problems	____	____
28. HIV+	____	____

Explain all yes responses:

_____
_____
_____
_____

Are you taking any medications?
YES _____ NO____

If yes list all medications:

_____
_____
____

Have you had any operations?
YES ___ NO ___
If yes provide a surgical history.

_____
_____
_____

Have you had any recent accidents or injuries? (e.g. back, head, etc)
YES ___ NO ___
If yes describe each accident/injury

_____
_____
_____
_____
_____

Do you have any allergies?
YES ___ NO ___
If yes, describe your allergies and how they are treated

_____
_____

Have you ever been treated for psychological problems?
Yes ___ No ___

If yes describe:

_____
_____
_____
_____
_____
_____

I have had the following Childhood Diseases:

	Yes	No
Rubeola	___	___
German Measles	___	___
Mumps	___	___
Chicken Pox	___	___

My signature below indicates that all information provided is true and accurate to the best of my knowledge.

_____
STUDENT SIGNATURE

This side must be completed by
an authorized Health professional

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PHYSICAL EXAMINATION
LABORATORY AND IMMUNIZATION REPORT

Ht _____ Wt _____ BP _____ Pulse _____

	NL	Comments
Eyes		
Ears		
Throat		
Teeth		
Gums		
Neck		
Chest		
Heart		
Lungs		
Abdomen		
Inguinal Rings		
Neurological		
Skin		
Genitourinary		
Back		
Extremities		
Pelvic(optional)		

Laboratory Test Results

Hemoglobin _____
Urinalysis _____

IMMUNIZATION: RESULTS/DATE

Tetanus Booster _____
TB-PPD*_____(Two-step required)
*Chest X-Ray (if positive)_____
Hepatitis Screening _____
Vaccination* (if Hepatitis Screening indicates lack of immunity) _____
* Or sign a waiver
Rubella Titre _____
Measles Vaccination _____
(recommended if Rubella Titre indicates lack of immunity)

RECOMMENDED:
RESULTS/DATE
Polio Vaccination _____
Influenza Vaccination _____

HIV Screening _____

ACTIVITY RATING:

( ) No Limitations, physically and mentally able to work as health care professional in acute care settings.
( ) Clinical/physical/mental Limitations: (please describe)

(Comments)_____

Health Professional Name(PRINT)_____Phone_____

Signature _____ Date _____

(Physician or authorized health care professional, acknowledges you have reviewed page one as well and have checked the appropriate activity rating)

Forms:B:Spring2012/Phys.Pg2