WILCO AREA CAREER CENTER

500 Wilco Blvd.
Romeoville, IL 60446

PHYSICAL EXAM FORM

To be completed by student:

Name_____ Home School_____

Address_____
Street City State Zip

Phone #_____

E-mail address _____

Birthdate_____ Age_____

Person to notify in case of emergency:

Name_____

Phone#_____

Relationship_____

Family Physician_____

Phone_____

Address_____

To be completed by physician:

Immunizations:

Tuberculosis skin test:#1.Date given:_____Date read/reaction: _____
(2-step Mantoux)
#2.Date given:_____Date read/reaction: _____
TB Tine test is not acceptable.

Documentation of a 2 Step TB Mantoux test is required prior to the start of clinicals. The second Mantoux test must be administered within 7-21 days of the first test, if the reaction to the initial test is negative. A single step Mantoux is adequate if a 2 step Mantoux was done within the past year. **TB Tine is not acceptable.** If a student has a recorded positive Mantoux, a chest x-ray is required.

*Reaction at test site should be read within 48-72 hours.

PHYSICIAN: In the section below, denote whether area is within normal limits (WNL) or abnormal. Record details in the remarks section.

WNL	ABNORMAL	
_____	_____	General Appearance
_____	_____	Eyes (Include lids, pupils, fundi, EOM)
_____	_____	Nose
_____	_____	Mouth
_____	_____	Throat (Include pharynx, tonsils)
_____	_____	Teeth and Gums
_____	_____	Neck (Include carotids and thyroid)
_____	_____	Lymph Nodes (cervical axillary, inguinal, epitrochlear)
_____	_____	Chest and lungs
_____	_____	Heart (Size, rhythm, murmur, quality of tones, thrill)
_____	_____	Abdomen (appearance, liver, spleen, scars, mass, tenderness)
_____	_____	Hernia (umbilical, inguinal, femoral, incisional)
_____	_____	Extremities (Feet, edema, pulses, ROM, deformity)
_____	_____	Skin
_____	_____	Rectal
_____	_____	Pelvic
_____	_____	Back (attention to list, pelvic, tilt, scoliosis, ROM)
_____	_____	Neurological (Include reflexes)

Explain any checks in the abnormal section. (Note asthma or diabetes)

Student is able to participate in all aspects of the course (clinical included) without restrictions.

Physician signature:_____ Date:_____

Physician name printed:_____

_____

Street Address City State Zip Code

Phone #_____

OFFICE USE:

DATE RECEIVED_____